Municipal postnatal healthcare

The perspectives of parents and nurses

by

Bente Kristin Høgmo

Thesis submitted in fulfilment of the requirements for the degree of
PHILOSOPHIAE DOCTOR
(Ph.D.)

University
of Stavanger

Faculty of Health Sciences
Department of Public Health
2023

University of Stavanger
NO-4036 Stavanger
NORWAY
www.uis.no

ISBN: 978-82-8439-196-0
ISSN: 1890-1387
PhD: Thesis UiS No. 728

Forsidebilde:
«Mørketid» malt av kunstneren Lars Utstøl

Acknowledgements

I would like to express my sincere gratitude to all who have contributed and supported me in different ways in the work with this PhD thesis.

First and foremost, my thanks go to the parents who took part in this study and for sharing their experiences and thoughts with me, and to the midwives who helped with the recruitment. Without their contributions and willingness to participate, this thesis would not have been possible.

My deepest gratitude goes to my main supervisor, Associate Professor Marit Alstveit and my co-supervisor, Professor Terese Bondas, University of Stavanger, who have guided and supported me through this research project with great professional commitment and most of all, with lots of care. It has been a privilege to be surrounded by such a dedicated team and benefit from their knowledge, constructive criticism and motivational enthusiasm.

I also thank the user participants for their engagement and for contributing important knowledge in the initial phase of the study.

Acknowledgements also go to University of Stavanger, represented by the Faculty of Health Sciences, for funding my doctoral fellowship.

Thanks to Professor Birgitta Haga Gripsrud, University of Stavanger and Professor Anne Clancy, UiT, The Arctic University of Norway, for your valuable comments on my seminars. I am also very grateful to Professor Hanne Aagaard, Aarhus University, who made the arrangements for my research stay in Denmark.

Thank you to my dear colleagues and fellow PhD students at Faculty of Health Sciences and Department of Public Health at University of Stavanger, and everyone in the research group HevHelse.

I am also very grateful to my fellow PhD students in the National network of PhD students in public health nursing and the research school Muni-Health-Care.

Special thanks to Sara Fernández Basanta, University of A Coruña, for friendship and good conversations, and thanks to my dear friend Yvonne for always being interested in my work and cheering me on.

Thanks also to my friends and family for their thoughtfulness and understanding when I have spent a lot of time in the office immersed in time-consuming research. A warm thank you to Carina for always being wise, caring and encouraging - even though it is a long distance between us, our digital coffee breaks have been of great importance to me.

Finally, I wish to thank my dear family, my husband Jørgen, our children and children-in-law; Sigurd, Ida and Kenneth, Emil and Lina for their love, endless support and for always believing in me. A special thanks to our wonderful grandchildren Emilie and Luca, for reminding me what is most important in life. I love you all!

Summary

Background: Postnatal healthcare is a key component of the maternal, newborn and childcare continuum and contributes to improved health outcomes for women, babies and their families in the first six weeks after birth. The length of stay at hospital after giving birth has decreased steadily over the last 70 years, and today discharge within 24 hours after birth is not unusual. The responsibility for care during the initial postnatal period is thereby transferred from the hospital to the municipal postnatal healthcare services, the child's father (or non-birthing parent) and other family members. Despite an increasing focus on the significance of the father and the family in relation to the mother and baby in the postnatal period, the body of knowledge related to how fathers, parental couples and public health nurses experience and perceive postnatal healthcare is scant. Caring science, with the caritative caring theory, and the theory of being with child and a caring fellowship were chosen as the theoretical perspectives for this thesis.

Aims: The overall aim of the thesis was to explore and describe new parents' experiences and to integrate and synthesise knowledge of nurses' perspectives on municipal postnatal healthcare in three studies. A synthesis of how fathers, parents and nurses experience and perceive municipal postnatal healthcare was created. The research aims were the following: I) To describe new fathers' expectations of and experiences with municipal postnatal healthcare services; II) To describe parents' joint and individual experiences with public health nursing and child and family health centre services in the postnatal period; and III) To integrate and synthesise knowledge of nurses' perspectives on municipal postnatal healthcare.

Methods: This thesis has an explorative, descriptive and synthesising design, and a combination of a phenomenological and hermeneutic approach was used. The data in studies I and II was collected by using semi-structured couple and individual interviews with ten parental couples (ten mothers and ten fathers), while study III was a meta-ethnography of 13 qualitative studies. The data from the interviews was analysed according to Dahlberg, Dahlberg and Nyström's reflective lifeworld research approach and the meta-ethnography followed the interpretative process as described by Noblit and Hare. The findings of the studies were synthesised and lifted to a higher level of abstraction to achieve the ambition of the thesis to strengthen the body of knowledge of public health nursing and contribute to the development of postnatal healthcare of the family.

Results: Study I describes new fathers' expectations of and experiences with municipal postnatal healthcare services. The essential meaning structure for the phenomenon is described as *Going blindly into the women's world,* followed by four constituents elaborating the essence: *Not knowing what to ask for, Feeling excluded, Seeking safety for the family* and *Longing for care.* The fathers experienced a lack of knowledge about postnatal care and a feeling of being excluded by the public health nurse and child and family health centre services dominated, and the child and family health centre were perceived as "a women's world". Security was essential for the fathers, who highlighted the home visit as a good experience. The fathers also described a desire to be acknowledged and taken care of in the postnatal period. Study II described parents' joint and individual experiences with public health nursing and child and family health centre services in the postnatal period. The essential meaning of the phenomenon is characterised by the parents as *longing to be seen and confirmed as unique individuals and as a family by the PHN when learning to care for their baby*. The meaning of the essence is further elaborated in the following four constituents: *Feeling a bit skinless with an increased need for care, Missing a dialogue about parenthood and family, Home visit as a family experience on the parents' premises* and *Mother is the messenger.* An increased need for both professional and lay care became prominent in the postnatal period. At the same time, a perception of a missing family perspective became evident from the parents’ reflections relating to their encounters with the public health nurse, as the focus appeared to be directed mainly at mother and baby. The home visit was experienced by both parents as concrete care and attention, enabling the establishment of a relationship, which contributed to increased security. The parents experienced how the flow of information and contact solely took place between the mother and the public health nurse. Hence, the mother seemed to take the role as a messenger between the father and public health nurse. Study III integrated and synthesised qualitative studies that illuminated and described nurses’ perspectives on municipal postnatal healthcare. The overarching metaphor of *Being a “warrior” to care for the new family* was adopted, accompanied by the following three themes: *Stretching human boundaries, Stretching system boundaries* and *Stretching knowledge boundaries*. The themes reflect how nurses stretch different boundaries to achieve their goal to provide the best possible care during the postnatal period, while the overarching metaphor offers a deeper understanding of the nurses as “warriors” who were willing to go the extra mile for the new families. A model of the synthesis of the findings across the three studies illustrates postnatal healthcare as it is experienced from the fathers’, couples’, and nurses’ “world”.

Conclusion: The findings reveal that becoming a mother or a father is an existential experience and a challenging transition for both parents. In a phase characterised by joy, upheaval and vulnerability, parents long to be cared for as a family, while learning to care for the baby. Even though parenting is seen as a joint project, the child and family health centre appears to be “a women’s world” from which fathers feel excluded, and it is the mother’s role to act as messenger between the father and the public health nurse. Both parents and nurses emphasise the home visit and the significance of the home environment in establishing a caring fellowship in the initial postnatal period. The home appears as “the family’s world” in which professional caring is experienced more on the family's terms. Notwithstanding challenges linked to a large workload and scarcity of resources, nurses stretch their boundaries to care for the new family.

Keywords: Postnatal period, postnatal healthcare, experiences, perspectives, parents, mothers, fathers, public health nursing, nursing, caring science, qualitative method, reflective lifeworld research, meta-ethnography.

List of papers

The thesis is based on the following papers, which will be referred to in the text by their Roman numerals:

Paper I

Høgmo, B. K., Bondas, T., & Alstveit, M. (2021). Going blindly into the women's world: a reflective lifeworld research study of fathers' expectations of and experiences with municipal postnatal healthcare services. *International Journal of Qualitative Studies on Health and Well-being*. DOI: 10.1080/17482631.2021.1918887

Paper II

Høgmo, B. K., Bondas, T., & Alstveit, M. (2022). Parents' experiences with public health nursing during the postnatal period: A reflective lifeworld research study. *Scandinavian Journal of Caring Sciences*. DOI: 10.1111/scs.13117

Paper III

Høgmo, B. K., Alstveit, M., & Bondas, T. (2023). Being a "warrior" to care for the new family - a meta-ethnography of nurses' perspectives on municipal postnatal healthcare. Submitted and in review.

Table of Contents

Acknowledgements iii

Summary v

Prologue xi

Part I xiv

1 Introduction 1

- 1.1 The structure of the thesis 5

2 Background 7

- 2.1 Postnatal healthcare 7
  - *2.1.1 Postnatal healthcare in a global perspective 7*
  - *2.1.2 Postnatal healthcare in Norway 8*
  - *2.1.3 The child and family health centre service 9*
  - *2.1.4 The home visit 10*
  - *2.1.5 The role of the public health nurse 11*
- 2.2 Previous research 12
  - *2.2.1 New parents' perspectives 12*
  - *2.2.2 The perspectives of mothers 14*
  - *2.2.3 The perspectives of fathers 15*
  - *2.2.4 The perspectives of nurses 16*
  - *2.2.5 Summary of previous research 17*
- 2.3 Clarification of key concepts 18

3 Theoretical perspectives 21

- 3.1 Caring science as ontological foundation 21
- 3.2 The theory of caritative caring 22
  - *3.2.1 The human being seen as an entity 23*
  - *3.2.2 Perspectives on health 24*
  - *3.2.3 The caring relationship 25*
- 3.3 Being with child and caring communion 26

4 Methodology and methods 29

- 4.1 Phenomenological approach 29
- 4.2 Hermeneutics 30
- 4.3 Pre-understanding 31

4.4 Methods 34

4.5 Studies I and II 36

4.5.1 Reflective lifeworld research approach 36

4.5.2 Preparations for the study 37

4.5.3 Setting, participants and recruitment 38

4.5.4 Data collection – joint and individual interviews 39

4.5.5 Analyses 41

4.6 Study III 43

4.6.1 Meta-ethnography 43

4.6.2 Systematic searches and quality assessment 45

4.6.3 Analysis and synthesis 46

4.6.4 Synthesis of the studies 48

4.7 Methodological considerations 49

4.7.1 Paper I and II 49

4.7.2 Paper III 51

4.8 Ethical considerations 52

5 Summary and synthesis of the findings 55

5.1 Study I 55

***Going blindly into the women's world: a reflective lifeworld research study of fathers' expectations of and experiences with municipal postnatal healthcare services** 55*

5.2 Study II 56

***Parents' experiences with public health nursing during the postnatal period: A reflective lifeworld research study** 56*

5.3 Study III 58

***Being a "warrior" to care for the new family – a meta-ethnography of nurses' perspectives on municipal postnatal healthcare** 58*

5.4 Synthesis of the findings across the studies 59

6 Discussion 63

6.1 Postnatal healthcare seen from the father's world 63

6.2 Postnatal healthcare seen from the couple's world 65

6.3 Postnatal healthcare seen from the nurses' world 69

6.4 The home visit as the key to the new family's lifeworld 71

6.5 Methodological reflections 75

7 Conclusion 79

References 85

Part II 107

Papers.. 108

Paper I.. 109

Paper II.. 123

Paper III 135

Paper III - Appendices.. 161

Appendices 175

Appendix I - Approval from the regional ethics committee (REK) 175

Appendix II - Approval from the Norwegian Agency for Shared Services in Education and Research (SIKT) and data management plan 182

Appendix III - Information letter and consent form 186

Appendix IV - Interview guide, joint and individual interviews...................... 190

Appendix V - Overview of studies included in previous research 193

Table of Figures

Figure 1 Overview of the aims and research questions of the studies......................... 4
Figure 2 The heuristic synthesis "Being with child" 26
Figure 3 The home visit as the "key" to the new family’s world 60

List of Tables

Table 1Search strategy 12
Table 2 Overview of the study design 35
Table 3 Example of the three phases of data analysis.. 42
Table 4 Extract from search strategy.. 45
Table 5 Extract from translations to sub-themes, themes, and overarching metaphor 47

Part I

Prologue

Aurora and her father took a good look around when they entered the room. On the benches along the wall, mothers sat in rows, each with a bundle on their lap. There were many ladies who were chatting with each other, but suddenly they all fell completely silent and just stared at Aurora and her father. Some of them came over and asked if they needed help undressing the baby. “No, thank you very much,” Aurora’s father said. “Thanks for the offer, but Socrates probably likes to be undressed by those who know him best.” “How old is he then?” the ladies asked. “He’s eight weeks tomorrow,” Aurora’s father answered. The ladies went back to their seats, but they sort of kept an eye on them the whole time. Aurora wanted so much to help her father, so that everyone could see that it was all right for him to be there. They might have thought that he didn’t know anything. Maybe the ladies thought he had never cared for a baby before.

Extract from the book *Aurora in block Z,* by Anne-Cath. Vestly, 1966
(My own translation)

1 Introduction

This thesis focuses on how new fathers and parents experience public health nursing and child and family health centre (CFHC) services, as well as nurses' perspectives on municipal postnatal healthcare. For many new mothers and fathers, becoming parents is one of the biggest things they can experience in life, but perhaps also an event that changes their previous existence the most (Wiklund et al., 2018; Sacks et al., 2022). For most people, it is a great joy, but also an upheaval that represents new obligations and challenges. How parents experience welcoming a new baby might have consequences for their attachment to the child, and how the family is doing as a whole is thus of great importance for the child's well-being and development (Delicate et al., 2018; Valla et al., 2022).

Postnatal healthcare is a significant aspect of the maternal, newborn and childcare continuum. It can be defined as care provided during the postnatal period, which starts immediately after the baby is born and lasts for up to six weeks (WHO, 2022). The World Health Organisation (WHO) recommends that all women and their newborn babies receive postnatal healthcare within the first 24 hours after birth, and subsequent postnatal check-ups during the first six weeks (WHO, 2022). Postnatal care and healthcare services are designed to promote the health of newborn infants, women and their families. This includes risk identification, preventive measures, health promotion and education, and management of referral for complications. In addition to improving mortality rates and clinical care, postnatal healthcare affects the experience and satisfaction of healthcare users (WHO, 2022). It is also recommended to promote the involvement of men during pregnancy, childbirth and in the postnatal period, given the important role of men as partners/husbands, fathers and community members (WHO, 2015). Understanding the needs and lived experiences of women, their partners and families regarding postnatal healthcare might improve utilisation and make their experience more positive.

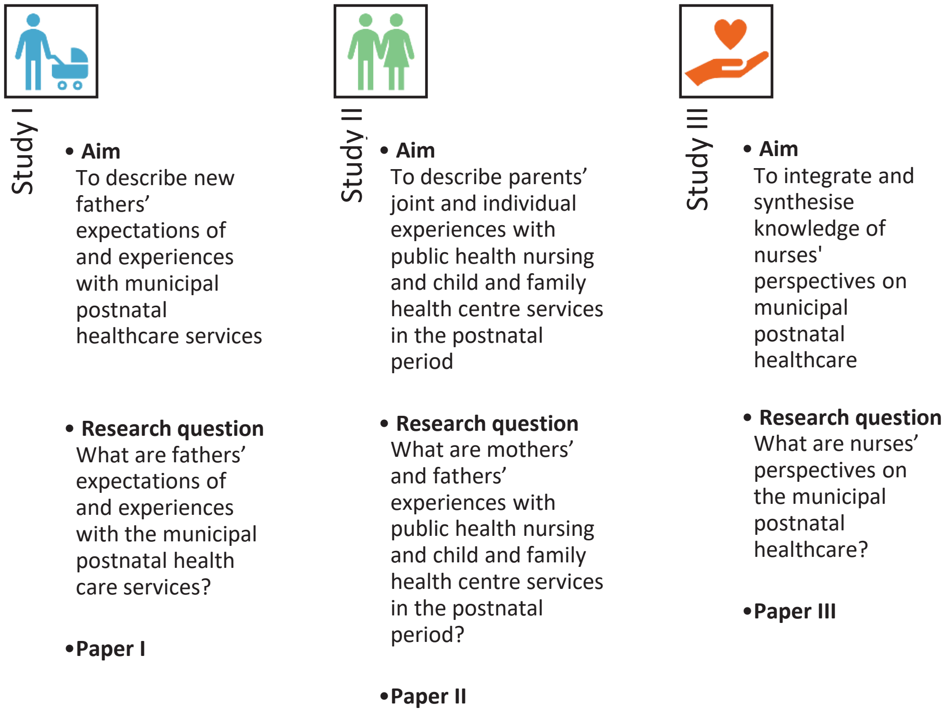
Early postnatal discharge from hospital after childbirth has become common in many countries and marks a shift in maternity care from an illness orientation to a more family-centred approach (Campbell et al., 2016; Jones et al., 2021). In many Western countries the length of hospital stay for mothers and babies has decreased steadily since the 1950s (Eberhard-Gran et al., 2010). The average length of hospital stay in Norway is now 2-3 days and within a few years, the discharge of healthy mothers and term babies is planned to be from four to 24 hours after birth (The Norwegian Directorate of Health, 2014). There is ongoing debate of the reduction of the length of stay in hospital for women who have given birth, and many healthcare professionals are concerned and warn against sending mothers and newborn infants home too early (Nilsson et al., 2017; Sievertsen & Wüst, 2017).

Norwegian maternity and postnatal healthcare maintains high quality standards in an international perspective (St. meld.nr. 12, 2008-2009). The infant mortality rate is very low and in the two-year period from 2019 to 2021, the number of children who died 0-27 days after birth (neonatal deaths) was 1.3 per 1,000 live births (SSB, 2023). At the same time, postnatal healthcare in Norway, as in many other countries (St. meld.nr.,12, 2008-2009; Wells, 2016; WHO, 2022), is the area of overall pregnancy, birth and maternity care with which many users express dissatisfaction. The Norwegian government emphasises that the services must be developed and improved continuously and that there is a need for systematic gathering of user experience and information from healthcare professionals, to learn which areas of postnatal healthcare should be improved, and how (St. meld.nr. 12, 2008-2009). This study is thus based on several restructurings of postnatal healthcare to a shorter hospital stay after birth. Early discharge transfers the responsibility for care and follow-up during the early phase after birth from the hospital to municipal postnatal healthcare, and to the family (Kurth et al., 2016).

I want to shed light on how the provision of municipal postnatal healthcare meets the needs of the new family, whether the public health nurse (PHN) and CFHC services are able to meet new fathers' needs and expectations, and also illuminate nurses' perspectives on municipal postnatal healthcare.

Aims and research questions

The overall aim of this doctoral thesis is to explore and describe new parents' experiences and to integrate and synthesise knowledge of nurses' perspectives on municipal postnatal healthcare. Based on the three studies, with the following aims and research questions, presented in Figure 1., I will also create a synthesis of the fathers', parents' and nurses' experiences and perspectives on the municipal postnatal healthcare. The goal is to strengthen the body of knowledge of public health nursing and contribute to the development of postnatal healthcare of the family.



Study I

- **Aim**
  To describe new fathers' expectations of and experiences with municipal postnatal healthcare services
- **Research question**
  What are fathers' expectations of and experiences with the municipal postnatal health care services?
- **Paper I**

Study II

- **Aim**
  To describe parents' joint and individual experiences with public health nursing and child and family health centre services in the postnatal period
- **Research question**
  What are mothers' and fathers' experiences with public health nursing and child and family health centre services in the postnatal period?
- **Paper II**

Study III

- **Aim**
  To integrate and synthesise knowledge of nurses' perspectives on municipal postnatal healthcare
- **Research question**
  What are nurses' perspectives on the municipal postnatal healthcare?
- **Paper III**

Figure 1 Overview of the aims and research questions of the studies

1.1 The structure of the thesis

This thesis consists of two parts. Part I comprises seven chapters, of which Chapter 1 provides an introduction of the topic, aims and research questions to be answered. Chapter 2 presents the background, concepts and previous research on postnatal healthcare from the perspectives of parents and nurses, followed by Chapter 3, which outlines the theoretical perspectives of the thesis. Chapter 4 describes the research methodology, data collection methods, analysis, and methodological and ethical considerations. In Chapter 5, a brief summary of the findings from the three studies is presented, followed by a synthesised understanding of how the studies contributed to fulfilling the overall aim of the thesis. Chapter 6 discusses the findings through the lens of the chosen theoretical perspectives and previous research, and ends with methodological reflections. Finally, Chapter 7 provides a summarising conclusion and implications for practice, health policy, education and further research. Part II of the thesis contains the three original research papers on which the thesis is based, and the appendices.

2 Background

The following chapter describes postnatal healthcare in a global and Norwegian context. Furthermore, this chapter presents previous research of parents’ and nurses’ experiences and perspectives on postnatal healthcare. Finally, a clarification of key concepts relevant to this thesis is presented.

2.1 Postnatal healthcare

2.1.1 Postnatal healthcare in a global perspective

According to WHO (2022), globally more than three in ten women and babies do not have access to postnatal healthcare in the first critical days after birth, which is the period when most maternal and infant deaths occur. To improve the situation and ensure the quality of postnatal care, the first ever global guidelines to support women, babies and the new family in the first six weeks after birth was launched by WHO in March 2022. These new guidelines highlight the importance of both physical and mental healthcare and include recommendations for breastfeeding counselling and to support parents in providing responsive care for their newborns (WHO, 2022). Postnatal care services are a key to achieving the Sustainable Development Goals (SDGs) on reproductive, maternal and child health (WHO, 2022) and the recommendations describe minimum hospital stay and discharge criteria based on the individual needs of woman and newborn, birth experience, social context and health concerns. Interventions to promote the involvement of men in postnatal healthcare emphasise the understanding of men and women’s joint responsibility, so that they become equal partners in their private and public lives. They are also a way of promoting egalitarian decisions about reproductive and maternal health (WHO, 2015).

Internationally, the organisation of postnatal healthcare varies in terms of who provides it, for how long women and babies receive care, and whether this is in hospital, in the community setting or at the family's home (WHO,2010). In developed countries, virtually all women and babies receive postpartum and postnatal healthcare, while in low- and middle-income countries the postnatal care coverage tends to be relatively poor (Langlois et al., 2015). In most developed countries postpartum hospital stays are often shorter than 48 hours following a vaginal birth and consequently, most postnatal care is provided in community- and ambulatory-care settings (Yonemoto et al., 2014).

2.1.2 Postnatal healthcare in Norway

In the Middle Ages, women who had just given birth were considered impure for 40 days and both mother and baby had to be looked after carefully, because they were believed to be particularly exposed to evil forces (Eberhard-Gran et al., 2010). In our time, most of the maternity customs that were common at that time have almost completely disappeared and just from the 1950s until today, there have been major changes in how birthing women and postnatal care are viewed. Seventy years ago, it was common in Norway for mother and newborn to stay in hospital for up to 14 days after childbirth. Around ten years later, the length of stay was reduced to around eight days, and further reduced to four to five days in the 1990s (Eberhard-Gran et al., 2010).

Today, discharge from hospital is common from 24 to 48 hours after childbirth. According to the *National guidelines for postnatal care*, it is explicitly stated that returning home can be planned from four to 24 hours after birth (The Norwegian Directorate of Health, 2014). This development has provoked concern and debate among both healthcare professionals and birthing mothers and fathers. In the wake of this development, the number of readmissions of both mothers and infants has risen, while studies of the relationship between length of stay and occurrence of complications in the newborn baby has revealed an increased risk of readmission due to complications after returning home within 24 hours after childbirth (Eberhard-Gran, 2018; Jones et al., 2021; Lindblad et al., 2021). New parents are in danger of not receiving the care and support they may need after early discharge, due to a lack of midwives and PHNs in the municipal healthcare services. In 2020, figures revealed a shortage of over 2,000 PHNs in Norway (Lassemo & Melby, 2010). Inspections by the Norwegian Board of Health Supervision (2014) have shown that many municipalities infringe the maternity guidelines' recommendations regarding home visits by health professionals. In some municipalities, new parents are not offered home visits after returning home from hospital, or only first-time parents have this opportunity for postnatal healthcare in their home environment. A new national survey of PHNs (Actis, 2023), in which 1,122 participated, shows that 62 per cent of the respondents answered that they had not offered new parents home visits, 60 per cent answered that they had not offered a maternity or network group, while 72 per cent answered that the workplace was understaffed. Limited resources affect the quality of the services and can hinder further development of the services (Andersen et al., 2022).

2.1.3 The child and family health centre service

Under the Health and Care Services Act (2011, Section 3-2), municipalities in Norway are required by law to have a child and family health centre (CFHC) service for all children residing in the municipality. All non-hospital-based primary healthcare is the responsibility of the municipalities, with this decentralisation contributing to ensuring efficient distribution. While local governments are primary providers, the state maintains a regulatory role. This division of responsibility gives municipalities flexibility, within the framework of national standards and guidelines, to meet the needs of the population of the community when tailoring service provision (Mehrara, 2020). CFHCs for children aged 0-5 are universal, low-threshold, and free-of-charge health services for all children and their families. From birth until they start school, the children are offered 14 consultations at the CFHC (The Norwegian Directorate of Health, 2022). The CFHC service provides help and advice from PHNs, midwives, doctors and physiotherapists, with the aim of giving advice, guidance and support to women and men in their role as parents. In accordance with the national guidelines (The Norwegian Directorate of Health, 2022), the parents and their baby are entitled to a group consultation with a PHN (and physiotherapist if there is one) at four weeks, and an individual consultation with a PHN and a medical examination of the baby by a doctor at the CFHC at six weeks of age. In all consultations during the postnatal period, the goal is for the PHN to start with topics that the parents want to address, and the child's and family's needs, health, development and living conditions (The Norwegian Directorate of Health, 2022).

2.1.4 The home visit

After birth, a home visit by a midwife is recommended from one to three days after the mother and baby have returned home from hospital (The Norwegian Directorate of Health, 2014). Furthermore, it is also strongly recommended that all newborns are offered a home visit by a PHN within seven to ten days after birth (The Norwegian Directorate of Health, 2022). The objective of the home visit by a PHN is to provide the parents with individual and necessary information, and support and guidance as needed, and to establish contact at an early stage, preferably with both parents present, to lay the foundation for further follow-up of the child and cooperation with the family (The Norwegian Directorate of Health, 2022). In addition to this, and after an individual assessment, an additional home visit or consultation between the 14th and 21st day after birth is suggested.

Home visits to all new families are a cornerstone of the Norwegian CFHC service and, as it is universal, are perceived as a natural element of the municipal health service (Hjälmhult, 2019). Home visits complement consultations at a CFHC and provide a more comprehensive picture of the child's family situation. Although home visits are said to be a time-consuming working method, it is emphasised that they present many advantages. They are a good starting point for the follow-up of families with children in their own arena, and a good entry point for prevention, health promotion and early intervention (Glavin, 2019). The home visit also contributes to ensuring individual care and guidance, and when the PHN focuses on one family at a time, this contributes to increased security and satisfaction (Hjälmhult, 2009, 2019; Nilsson et al., 2015).

2.1.5 The role of the public health nurse

In Norway, PHNs play a major role in health promotion and disease prevention work in society, especially for children, young people and their families. Norwegian public health nursing with CFHC services and school health services were founded in the early 1900's, and in 1947 the first school of public health nursing was established (Schiøtz, 2003). PHN is the only profession aimed specifically at the target group of children and young people aged 0-20 and their parents (NSF, 2011). A PHN has a Bachelor of Nursing and higher education in health promotion and primary preventive work, and today a growing number of PHNs also hold a master's degree in public health nursing in Norway. A PHN's caseload is limited to a defined geographical area; this can include both the CFHC and school health services, but does not comprise 'hands on' nursing (Clancy, 2007). The tasks of a PHN are both varied and comprehensive and, according to the national guidelines (The Norwegian Directorate of Health, 2022), include health examinations of children, breastfeeding guidance, vaccination, sexuality education, contraceptive guidance, and care and support for children, young people and their parents.

2.2 Previous research

Below I will provide an overview of previous research, presented from the perspective of parents, mothers, fathers and nurses, before concluding with a short summary. Continuous literature searches were conducted, related to writing both the three papers and the thesis. I have used both free text search and Boolean search modes, combining search terms with OR and AND. At the start of the doctoral project, I received guidance from a librarian regarding the choice of keywords, how to combine these and which databases might be the most relevant. The searches were generally limited to research over the past 20 years. A table of the studies included can be found as an appendix (Appendix V). An overview of the search strategy is displayed in Table 1.

Table 1Search strategy

Databases	Cinahl, Medline, Embase, British Nursing Index, SveMed+, Scopus and Google Scholar
MeSH terms	“Mothers”, “Fathers”, “Parents”, “Public Health Nurses”, “Midwives”, “Nurses”, “Community Health Nursing”, “Home Nursing”, “Postnatal Period”, “Postnatal Care”, “Community health centres”
Title and abstract	mother*, father*, parent*, public health nurse*, midwi*, nurse*, health visitor*, postnatal*, postpartum*, municipal*, communit*, home*, child and family health centre*, child health centre*, expectation*, experience*, attitude*, view*, perspective*
Manual searches	reference lists, relevant journals and searches linked to relevant researchers

2.2.1 New parents’ perspectives

The postnatal period is a time of transition for the new family and adjustments need to be made both at the psychological, physical and social levels (Shaw et al., 2006; Sacks et al., 2022). Parents’ ability to manage this transition might impact their relationship and the well-being of the baby and the rest of the family (Bäckström et al., 2018; Delicate et al., 2018; Valla et al., 2022). When the postpartum hospital stay is reduced, the parents' readiness for discharge must be identified, risk assessment conducted and individualised care provided (Johansson & Thies-Lagergren, 2022). In low-risk pregnancies, an early return home, with home visits and good support from healthcare professionals, is found to contribute to increased security and more family-centred postnatal care (Johansson et al., 2010; Askelsdottir et al., 2013; Thies-Lagergren & Johansson, 2023). Hence, the organisation of home-based postnatal care and how healthcare professionals support the new family, is important in the early postnatal period (Rautio, 2013; Nilsson et al., 2015; Johansson et al., 2019; Walker et al., 2019). As found in a systematic review by Wiklund et al., (2018) family-centred care that features continuity of care, individually adapted and consistent information, parental participation and preparation for parenting is an important factor in ensuring parents' postnatal sense of security. As parents postnatally see parenting as a joint project, midwives and nurses must acknowledge the parents' emotional attachment and their efforts to achieve equal opportunities and the support of the healthcare system (Ellberg et al., 2008). Family-centred care contains important components in relation to parents feeling of security and inclusion of the whole family in postnatal care (Wiklund et al., 2018).

The literature search reveals differences in how the parental experiences are described, with the initial postnatal period being characterised by a wealth of emotions, ranging from anxiety and insecurity to affinity and calmness (Barimani et al., 2017; Werner-Bierwisch et al., 2018; Wiklund et al., 2018). The combination of the infant's requirements and self-care needs after hospital discharge entails a significant need for practical support, monitoring and care (Kurth et al., 2016). Individualised postnatal follow-up and access to healthcare professionals are other important aspects of care during the postnatal period (Danbjørg et al., 2014). As found by Danbjørg et al. (2014), families might experience a barrier when contacting healthcare professionals and might therefore prefer to use family, friends or the internet, thereby asking for new ways to communicate.

2.2.2 The perspectives of mothers

Giving birth and entering the postnatal period represents a significant phase in the lives of new mothers (Finlayson et al., 2020; Walker et al., 2019). Research shows that women recognise the specific challenges of the postnatal period and emphasise the need for both clinical care, and psychosocial and emotional support (Sacks et al., 2022). Basic needs such as sleep, nutrition and pain relief are occasionally suppressed in the early postnatal phase, because the mother's focus on breastfeeding and caring for the baby is dominant (Hjälmhult & Lomborg, 2012; Tveit & Söderhamn, 2015; Dahlberg et al., 2016). Parenting competence and confidence begin to emerge in the first weeks after birth. Inadequate breastfeeding support, both in hospital and at home, might contribute to breastfeeding challenges and complications, which can impact a mother's decision to breastfeed or not, which again may affect the baby's health and well-being (Zadoroznyj et al., 2015; Rydström et al., 2021). New mothers might lack confidence in themselves and their ability to care for their baby without the support of professionals (Forster et al., 2008). Women need psychological support and information about the transition to parenthood (Slomian et al., 2017) and it is important that they have the opportunity to prepare in advance, so they know what to expect as new mothers (Barimani & Vikström, 2015).

Research of women's expectations and experience of postnatal care shows that mothers' satisfaction with the care and their confidence as new mothers seem to be influenced primarily by the extent to which their postnatal needs are met; whether they have the opportunity to decide for themselves when to be discharged from the maternity ward; and whether a women who wants a postnatal home visit by a midwife after birth is offered this service (Lindberg et al., 2008; Kronborg et al., 2012).

The number of lesbian, gay, bisexual, transgender and queer (LGBTQ) parents is growing around the world. Research shows that although same-sex mothers in the Nordic countries generally have positive experiences from encounters with child healthcare professionals, they also face organisational and staff-related challenges that influence their healthcare and transition to parenthood (Wells & Lang, 2016; Appelgren Engström et al., 2019). Same-sex mothers aim for equality and express the wish to be treated as a family by professionals at child healthcare services.

Several studies shows that PHNs and midwives can play an important role in contributing to safety, helping mothers to cope, thrive and develop confidence, and that the postnatal period gives unique opportunities for this preventive work (Forster et al., 2008; Alstveit et al., 2010; Persson et al., 2011; Haga et al., 2012).

Home-based postnatal care after discharge is well-accepted by mothers, and women who have received early home visits report higher scores for continuity and predictability, while also experiencing a significant impact on their ability to cope with caring for the newborn, on their mental health and on their sense of being acknowledged and supported (Dahlberg et al., 2016; Aune et al., 2018; Johansson et al., 2019).

2.2.3 The perspectives of fathers

Over the past few decades, the role of fathers has changed and men now want to be more involved in family life and to take more responsibility for childcare duties (Chin et al., 2011; Shorey & Ang, 2019). The impact of paternity leave and paternal involvement in the early weeks and months of childhood has become a focus of policy concern in many countries across the world (Leahy-Warren et al., 2022). Research has shown that the transition to fatherhood can present social, emotional, physical and psychological changes for fathers, as well as mothers (Steen et al., 2012; Werner-Bierwisch et al., 2018; Solberg et al., 2022) and there are studies showing that fathers also need support during the postnatal period (Kowlessar et al., 2015; Shorey et al., 2017; Hrybanova et al., 2019). First-time fathers in particular are found to experience a number of emotional reactions in the initial phase after becoming a father, and having to return to work reinforces these reactions (Chin et al., 2011; Baldwin et al., 2018). Studies of fathers and postnatal depression (PND) demonstrate the significant impact of PND and parental stress on the parents' spousal relationship and everyday life (Eddy et al., 2019; Johansson et al., 2020). One of the studies emphasises the importance of the CFHC identifying and supporting fathers with depressive symptoms (Edhborg et al., 2016).

While postnatal care seems to meet the needs of women, many men still feel like outsiders with limited involvement in the child health field and a variety of factors that affect their engagement are detected (Thomas et al., 2011; Wells, 2016; Hodgson et al., 2021; Finlayson et al., 2023). A review of fathers' self-reported well-being needs in the first postnatal year (Black, 2023) concluded that, if left unsupported, fathers might develop significant physical and emotional mental health difficulties, which would be detrimental to paternal well-being, as well as the mental health of the infant and the entire family.

2.2.4 The perspectives of nurses

Acknowledging that the transition to parenthood might involve a number of challenges enhances the importance of postnatal care (Garvan, 2016; Yonemoto et al., 2021). As described by Giltenane et al., (2021), where the practice of municipal postnatal healthcare exists, it is often undertaken by PHNs, health visitors or community midwives. Even though new parents expect healthcare professionals to be skilled and to meet their needs (Kurth et al., 2016), and the quality of nursing is high on the policy agenda internationally, evidence shows a lack of consistency and that professional practices vary within public health nursing (Noonan et al., 2017; Giltenane et al., 2022). The challenge of workload demands and a lack of resources also affects the quality of public health nursing and the quality of care provided (Giltenane et al., 2022; Kokab et al., 2022). One study of maternal needs after childbirth revealed that healthcare professionals seem to be more concerned about the mother’s needs during pregnancy than postnatally (Slomian et al., 2017), while another study of nurses’ recognition of PND in fathers found that more attention must be paid to the topic, due to lacking routines to assess the health and well-being of fathers (Hammarlund et al., 2015).

A qualitative study of nurses’ and midwives’ experience of supporting two-mother families shows that healthcare professionals need time to reflect on challenges and norms, so as to better support both mothers in the family (Engström et al., 2022). As shown by Engström et al. (2022), revising forms and documents to be gender neutral could help guide nurses and midwives to include a variety of family constellations.

2.2.5 Summary of previous research

The postnatal period and the transition to parenthood is recognised as a significant time in the lives of new mothers and fathers (Finlayson et al., 2020; Walker et al., 2019; Sacks et al., 2022). How parents manage the first weeks after childbirth can impact the well-being of the entire family (Hjälmhult & Lomborg, 2012; Dahlberg et al., 2016; Delicate et al., 2018; Valla et al., 2022). Studies show that early discharge can contribute to family-centred care and increased security (Johansson et al., 2010; Askelsdottir et al., 2013) if the home-based care meets the new parents’ support needs (Aune et al., 2017; Wiklund et al., 2018; Johansson et al., 2019; Walker et al., 2019). How parents experience postnatal care differs and individually adapted follow-up and access to healthcare professionals are important aspects to ensure parental confidence and security (Kurth et al., 2016; Werner-Bierwisch et al., 2018; Wiklund et al., 2018; Danbjørg et al., 2014). The literature review shows that even though fathers also have support needs during the postnatal period (Shorey et al., 2017; Hrybanova et al., 2019; Solberg et al., 2022), many fathers feel they are outsiders, and excluded from the child health field (Thomas et al., 2011; Wells, 2016). Inequality is also experienced by same-sex mothers who wish to be treated as a family by the healthcare professionals at the CFHC (Wells & Lang, 2016; Engström et al., 2019).

Although there is scant research of PHNs' perspectives, studies show the importance of postnatal care by acknowledging that the transition to parenthood might involve a number of different challenges for the new mothers and fathers (Garvan, 2016; Yonemoto et al., 2021). Studies show that there should be more focus on assessing fathers' and co-mothers' health and well-being (Hammarlund et al., 2015; Engström et al., 2022; Finlayson et al., 2023). On the other hand, tight timeframes, growing workload demands and a lack of resources are challenges described by nurses and midwives working in municipal postnatal healthcare (Giltenane et al., 2022; Kokab et al., 2022).

The literature review shows quite a large body of research related to mothers' experience of postnatal healthcare, while research is sparser when it comes to the experience of fathers and PHNs. Despite an increase in research of fathers' and parents' experience of postnatal healthcare in recent years, there is still a knowledge gap, which calls for more research related to this topic. The above results have also revealed that greater focus on PHNs' experiences and perspectives is needed, so as to contribute knowledge in the field of municipal postnatal healthcare.

2.3 Clarification of key concepts

The terms *postpartum period* and *postnatal period* are often used interchangeably, but sometimes separately. According to WHO (2010), *postpartum* refers to issues regarding the mother, while *postnatal* refers to those concerning the baby. To aid clarity in the papers and the thesis, one single term, *postnatal,* has been adopted for care after childbirth and addresses all issues pertaining to the mother and baby after birth. This is in line with the WHO recommendations (2010). In this thesis, the *postnatal period* is defined as the phase of life immediately following birth and extending for up to six weeks (WHO, 2018). The duration of the postnatal period is culturally variable, but the first six weeks are common cross-culturally (Eberhard-Gran et al., 2010) and are thus chosen as the definition.

Postnatal care, in this context, refers to the care offered by the health service in the municipality where the family lives, and the term *municipal postnatal healthcare* is often used in both the articles and the thesis. In Norway, as in several other countries, there are special health centres where parents and children (0-5 years) can get free and universal healthcare (The Norwegian Directorate of Health, 2022). These centres have various designations, such as healthcare centre, child healthcare centre, maternity and child healthcare centre and child and family health centre, etc. To underline the development and progress from primarily supporting mothers and children, to a current focus on the whole family, I use the term *child and family health centre* (CFHC) service. In Norway, both *public health nurses* (PHN) and *midwives* play a role in municipal postnatal healthcare. In studies I and II, the focus is on fathers' and parents' expectations of and experience with public health nursing and CFHC services, while in study III *nurses'* perspectives were included, to fit an international postnatal healthcare context. The term *nurses* embrace PHNs, midwives, child nurses, child and family health nurses, and health visitors, etc. (further elaborated in paper III). The terms PHN and nurse are therefore used interchangeably in this thesis.

3 Theoretical perspectives

A theoretical perspective can be understood as the lens through which we look, as a set of assumptions about reality that inform the questions we ask and the answers we arrive at as a result (Crossman, 2020). Human sciences lay the foundation for this thesis, and caring science, with its philosophical perspectives on health and caregiving, was chosen as my theoretical perspective. This perspective was not a predefined framework, as it emerged gradually during the research process. Different theories and fragments of theories, such as the Transitions theory (Meleis, 2010) and Family-centred care (FCC) (Coyne et al., 2018) were also considered during the work on the thesis, but ultimately it was the findings that led to the chosen theoretical perspective. The caritative caring theory, and the theory of being with child and a caring communion, help to give direction to the study and are explained in this chapter.

3.1 Caring science as ontological foundation

My angle of vision and the way I as a researcher and PHN approached this study is important to understanding why this piece of research becomes what it does and what sense we make of its contribution to the field of knowledge. Inspired by the work and contributions from the Nordic scientists and professors Kari Martinsen, Katie Eriksson, Karin Dahlberg and Terese Bondas, caring science, with its philosophical perspectives on health and caregiving, was chosen as my perspective on care in the postnatal period. In caring science, questions of life and existence form the basis for healthcare, and as it is not bound to any specific profession it can be studied by anyone interested in the scientific perspective (Arman et al., 2015). Existence itself and what it means to be a human being is the starting point in caring science, and the understanding of the “patient’s world” is a fundamental consideration (Eriksson, 2002; Martinsen, 2006; Dahlberg et al., 2009).

In this thesis, the concept of caring is related to the professional care of parents and their baby during the postnatal period. Caring is a word that is used in different ways and given different meanings (André, 2017). In relation to public health nursing and postnatal healthcare, the concept of care is naturally linked to Florence Nightingale’s thoughts and ideas about how the nursing profession should meet patients’ needs for healthcare (Monteiro, 1985). The word *nursing* has its origins in the Latin word *nutrire*, which means “give nourishment” and “support” (Online Etymology Dictionary, no year); while *caring*, which is the verbal noun from care, means “act or state of showing concern for others” (Online Etymology Dictionary, no year). Both nursing science and caring science are traditions with significance for the development of the nursing profession. While nursing science is understood as subject-specific, caring science is, as mentioned, autonomous and can be studied by all caregivers or by anyone interested in the scientific perspective (Eriksson, 2018; Arman et al., 2015).

3.2 The theory of caritative caring

The caritative caring theory represents a change from disease-, medical- and technically oriented and professional care to natural caring, as caring performed between human beings such as family members, friends and relatives (Eriksson, 2018). An important starting point is that caring is seen as a natural human behaviour that has also developed into professional caring (Bergbom, et al., 2022). In line with Eriksson, this thesis recognises that caring encompasses the whole individual and that the basic motive in caring is to alleviate suffering and promote and protect health and life (Eriksson, 2018).

Love, mercy and compassion are the basic objects and constitute the inner core of Eriksson’s theory of caritative caring (Bergbom, et al., 2021). Caritas means “love and charity” and represents unconditional love, which also constitutes the motive for all caring (Nyström et al., 2022). According to Eriksson (2018), caring is an endeavour to mediate faith, hope and love through tending, learning and playing. The word “tend” means closeness, to touch and take care of the whole body and can be seen as a source of development and growth, a concrete action of love. To play is a universal phenomenon and can be exemplified by small talk, an interactive process with the potential to contribute to trust and confidence and stimulate and promote health and growth. Playing in care helps the patient to adapt new elements into their own world by for example testing and training. For human beings, learning can be seen as fundamental for life and is related to growth, development and constant change (Eriksson, 2018; Bergbom et al., 2021).

Caring is constituted of ethos, which is closely related to ethics and reflects basic values such as caritas, human dignity, and the inviolability and holiness of life (Eriksson, 2018). The concept of ethos originates from the Greek language and is associated with morals, habits and character (Bergbom et al., 2022). According to Eriksson (2018), a person who has acquired an ethos is “at home in his or her own life” and radiates love. The person possesses a natural dignity and freedom, and is responsible and at the service of the human being. He or she also has a will to do their best.

3.2.1 The human being seen as an entity

Just as within the caring science perspective, I see the human being as an entity of body, soul and spirit, and we thus cannot separate a human being into parts, as a human being is always an indivisible entity (Arman et al., 2015). The human being is also seen as being in constant change and in constant becoming, and therefore never in a state of full completion (Eriksson, 2018). The transition to parenthood brings major changes for both parents, characterised by physical, emotional and social alterations. Mothers’ and fathers’ lived experience of pregnancy, birth and the postpartum period affects their need for care and support during the postnatal period. From a lifeworld perspective (Dahlberg et al., 2009), the concept of the lived body represents a way of seeing the human body as a subject going through lived experiences. Shifting the focus from a pathogenic view toward salutogenic powers is central to the perspective, which fits well with the health promoting focus in which PHNs enters the lifeworld of newborns, their parents and families.

3.2.2 Perspectives on health

Two important fundamental concepts in caring science are health and suffering. These concepts can be seen as dyadic, and as described by Eriksson (2018), human suffering is natural and a part of health. Eriksson defines health as an integrated state of freshness, soundness and well-being (Eriksson, 2018). This definition encompasses all aspects of the human being and, by recognising that it does not signify a complete absence of illness, health and suffering, can be studied as lived interconnected experiences (Bondas-Salonen, 1998). In a multidimensional perspective, health is a whole entity due to its connection with suffering. Health is made visible through suffering and suffering can thus be seen as an active substance in humans' health (Bergbom, et al., 2022).

Dahlberg has focused on patients' lifeworlds, on the concept of health and well-being, and on patients' participation in their own health and caregiving processes (Arman, 2015). In an existential and lifeworld-oriented view of well-being, vitality, movement and peace, as well as the idea of meaningful life projects are considered as to be cornerstones (Dahlberg et al., 2009). This offers a view that includes health and well-being, which also fits well with caring for the new family in the postnatal period. According to Dahlberg et al., (2009) this view of well-being is pivotal to lifeworld-led care, as it offers a direction for care and practice that has a positive health focus.

As healthcare professionals, we must recognise that not all relationships between a caregiver and a care recipient are characterised by caring. In situations where a lack of caring manifests itself, suffering linked to the absence of caring can occur. Eriksson (2018) describes three different forms of suffering: suffering related to illness, suffering related to life and suffering related to care. Suffering related to illness is the patient's experience in relation to treatment and illness. Suffering may also represent the situation of being a patient and experiencing the whole of life as suffering, while suffering related to care is the suffering the patient (or mother or father) experiences due to care or an absence of care (Eriksson, 2018). This may be visual when PHNs and other healthcare professionals are part of a culture or an organisation that causes suffering through abuse of power or failure in caring. In a petrified and static care culture, predetermined care might prevail and be realised at the expense of the individual mother's or father's needs (Kasen, et al., 2008).

3.2.3 The caring relationship

Within caring science, the concept of the caring relationship is central (Eriksson, 2018; Bondas, 2003; Kasen et al., 2008; Arman et al., 2015). When the PHN provide care for the new family, this takes place in a relationship with the parents and the quality of the relationship determines whether the mother and father feel cared for. In accordance with Eriksson (2018), I take a wholeness view of the human being and see human beings as part of a social community in which caring and mutual dependence are central components. In this perspective, caring for others can be viewed as a natural part of being a human being, and the caring process as a reciprocal and interactive process (Eriksson, 2018). Eriksson sees caring as an act between two living human beings and she defines the relationship between caregiver and care recipient as existential and calls it a caring communion. At the same time, the relationship between a professional and a patient will always be asymmetrical, as their interactions are based on a power and dependence relation (Eriksson, 2018).

The interpersonal relationship can be designed in different ways and have different content, but what is important from a caring perspective is the authenticity of the relationship. In this caring communion, a space can be created in which both parties have the opportunity to be transformed by the caring relation (Eriksson, 2018). In the caring encounter, the caregiver's sensitivity and responsibility towards the interaction involve responding to the needs of the patients, and to their facial expressions and tone of voice, which leads to an obligation towards their lifeworld (Dahlberg et al., 2009).

3.3 Being with child and caring communion

The caring communion is also described and nuanced by Bondas (2003) in the clinical context of childbearing. In the heuristic synthesis "Being with child" (Figure 2), based on the results of her research of childbearing and care, three different forms of communion are made visible as family communion, caring communion and interpersonal communion.

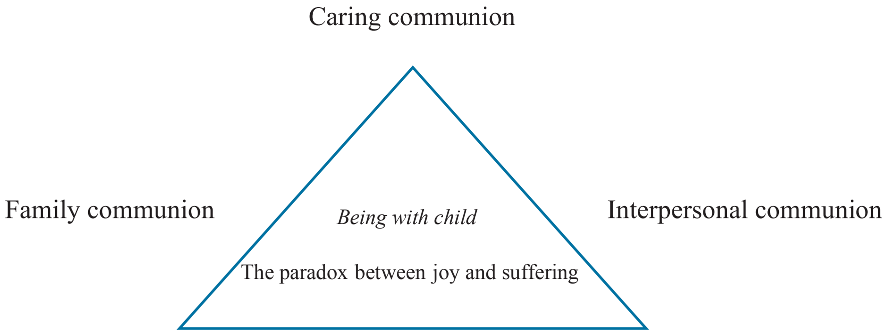


Figure 2 The heuristic synthesis "Being with child"

According to Bondas, the ontological core is the same in all three communions and dominant is the experience that the other has the will to do good. Through sharing in communion, relief from suffering and a deeper joy is described (Bondas, 2003). The differences seem to be related to the nature of the relationship and the reciprocity in the relationship, as well as an awareness of the purpose of the care directed at the patient. As a result, Bondas places the concept of caring communion within professional caring, to separate it from the natural caring in the family and interpersonal communion.

Family communion is understood as the parents striving for a new unit in which the unique family constellation is included. Hence, it can be seen as the birth of a new family, both on an abstract level and on a concrete level when a new baby enters the world. Interpersonal communion is described as the relationship that can arise between women and couples who share common experiences related to being in the same life situation. As in the case of family communion, it is about creating a mutual relationship, with a desire and a willingness to both give and take. In this process, the professional care (caring communion) can help and support the family to develop into natural caregivers and contribute to preventing suffering in the family.

In line with Bondas (2003), this thesis acknowledges the lifeworlds of the mothers, fathers and their families as a starting point and the motive of caring in the postnatal period, and also emphasises the importance of sharing and listening in a phase of changes in health and life. Being able to ask questions and talk about childbirth and the transition to parenthood is important for both parents, as childbearing can be seen as an existential and relational experience (Dahl et al., 2020).

4 Methodology and methods

This chapter introduces the philosophical underpinnings and outlines the study design and methods of the thesis. A reflection on pre-understanding and its significance for the research, in addition to analytical approaches, is described and elaborated. Finally, the chapter concludes with methodological and ethical considerations.

4.1 Phenomenological approach

To gain a deeper understanding of the phenomenon studied, a combination of a phenomenological and hermeneutic approach was chosen. Phenomenology is the study of things as they appear and the goal of phenomenology is to expose the essence or inner core of the phenomenon; what the ‘thing’ is (Husserl, 2001/1900; Zahavi, 2018). In phenomenology, it is important not to take anything for granted, but to do full justice to the object studied, regardless of whether it is a mathematical or logical object; or emotions, physical things, cultural objects and social institutions (Bengtsson, 1988). Phenomenology seeks to understand what it means to be human and does not reduce the human world solely to what can be observed, measured and weighed, and is therefore suitable for studying phenomena such as the postnatal health care experienced by new mothers and fathers. To be able to grasp things as they appear in experience and conceptualise them, openness, sensitivity and sensibility are required. To meet this criterion of openness I have sought to “bridle”, which means keeping an eye on and keeping in check, my pre-understanding and the evolving understanding throughout the research process, to be able to open up and slow down the process of understanding so that it does not take place too randomly or too quickly (Dahlberg & Dahlberg, 2019).

Since both phenomenology and hermeneutics belong to the human sciences and have a common ground in the lifeworld theory, they are appropriate to describe and interpret human experience (Dahlberg et al., 2008). Merleau-Ponty (2005/1945) expresses the idea of lifeworld as being in the world where an understanding and awareness of the lifeworld is a necessary condition for knowledge. According to Merleau-Ponty, all knowledge that human beings develop is embodied knowing, and in the lifeworld approach, the notions of the subjective body and embodied knowing are fundamental aspects. According to Dahlberg et al. (2008), as human beings we live as subjects both in and through our bodies, and all of our understanding and perception, our memory, and cognitive and emotional relations to the world, are integrated in our subjective body – they are embodied. By sharing descriptions of the essence of new parents' experience of municipal postnatal health care, the meaning of that experience can be communicated and understood by other persons. Phenomenology forms the basis for studies I and II.

4.2 Hermeneutics

Hermeneutics is the theory of interpretation and the art of understanding, and it focuses on the lived experiences of the human being (Alsaigh & Coyne, 2021). Gadamer (2012/1960) described hermeneutics as a philosophical reflection on what understanding and interpretation are; how do we understand and what happens when we understand? Embedded in these assumptions is that, as humans, we experience the world through language and this language provides both understanding and knowledge (Byrne, 2001).

Pre-understanding, fusion of horizons and the hermeneutic circle are important concepts in hermeneutic philosophy and have been helpful in terms of "being and staying" open as a researcher during the entire research process. Gadamer's ontological view was that researchers are deeply influenced by the traditions of the culture in which they live, and he emphasises that tradition plays a significant role in interpretation and understanding (Converse, 2012). Gadamer describes interpretation as a fusion of horizons, a dialectical interaction between the meaning of the text and the pre-understandings of the interpreter. By adopting an open and “bridled” attitude, as Dahlberg et al. (2008) term it, I have sought to slow down the process of understanding actively, waiting for the phenomenon studied to appear. As stated by Dahlberg & Dahlberg (2019), neither phenomenologically nor hermeneutically oriented researchers can free themselves from their pre-understanding, as it is essential to understanding anything at all. Hence, it has been important to recognise and be aware of the influence my own lived experiences and theoretical perspectives have had on the ongoing research, allowing the research findings to “speak to me”.

The hermeneutic circle is described as a movement between the different aspects of the text and the interpreter, where the interpreter’s preconception is fused into the process and transferred into new understandings, as the process of understanding progresses (Suddick et al., 2020). In practice, this means that, as a researcher, I have had an encounter with people’s lived experiences in the form of both the spoken word and written text in all three studies, which has contributed to a new understanding that has changed my horizon of understanding and thereby my pre-understanding. Even though the thesis has its starting point in caring science, I did not have a predefined theoretical perspective during the research process, which allowed me to stop and dwell along the way, contributing to new ways of understanding.

Hermeneutics forms the basis for the methods in study III and the synthesis of the thesis and is also a central aspect of studies I and II.

4.3 Pre-understanding

The researchers always enter the field of investigation with their own opinions, personal beliefs and other assumptions about the subject, which is also termed ‘pre-understanding’ (Malterud, 2017). My pre-understanding is the ‘backpack’ that I brought with me into the research project before the project started. The contents of this ‘backpack’ will always affect how the researcher collects, reads and interprets data (Malterud, 2017). On the one hand, pre-understanding is an important aspect of researchers' motivation for initiating research of a particular theme. On the other hand, pre-understanding can cause researchers to enter a project with a closed mind and limited horizons. The most common pitfall is that the pre-understanding overshadows the message from the empirical material (Dahlberg et al., 2008). As a public health nurse, I have worked with families, children and adolescents for many years. It has thus been important for me to be aware of my own pre-understanding and to make my preconceptions explicit during the research process.

The work of supporting and caring for new families, especially in the early postnatal period, has always been close to my heart. My interest in health-promoting and disease-preventing work was already awakened when I was a student nurse in the early 1990s. During my later work as a PHN and from my own experience as a mother of three children, I developed an "insider's perspective" on this topic. Now that I am a PHN and a researcher, it is of great importance that I consider how my background and position have affected what I choose to investigate, the angle of investigation and the methods that I determine to be most appropriate for the study. Berger (2015) has stated that when a researcher shares their experience with study participants, the researcher assumes the role of an 'insider'. Thus, 'insider research' refers to 'when researchers conduct research with populations of which they are also members so that the researcher shares an identity, language, and experiential base with the study participants' (Dwyer & Buckle, 2009). This gives researchers several advantages when studying the familiar, as they have existing knowledge about the topic, and an easier entrée to participants and an understanding of the subjects' nuanced reactions. I believe that my insider status has given me as a researcher more complete and rapid acceptance by the research subjects. The research subjects were thus perhaps more open with me, so that the data gathered may be of greater depth. Subjects might be more willing to share their experience because they infer an understanding and shared distinctiveness between themselves and the researcher; it is as if they feel, ‘you are one of us and it is us versus them (those on the outside who do not understand)’ (Dwyer & Buckle, 2009).

In addition to sharing experience of the postnatal period and postnatal care, my research subjects and I might also share the same language and be interested in the same topics. As a researcher, mother and grandmother, I can identify with the parents, for example, when they speak of their joys and concerns, breastfeeding challenges, birth experience and their perceived need for help and support from healthcare professionals when they come home from hospital after the birth of their child. By remembering my own joys and challenges of being a new mother, and especially my experience of working as a PHN, I can better understand the parents I am interviewing. However, as Finlay (1998) experienced in her research, I must guard against assuming that the research subjects and I share the same language and meanings, thereby neglecting the differences that exist between us. During the first couple of interviews with the parents, I experienced that my pre-understanding with regard to postnatal care and home visits was characterised by a positive attitude, based on my previous experience as a PHN. By writing down my thoughts in my research diary after the interviews and discussing these experiences and findings with my supervisors, I could use this new insight to be more aware of my role as a researcher investigating a very well-known topic.

In qualitative research, total objectivity is neither achievable nor necessarily desirable. However, researchers are often required to set assumptions aside, so that the true experiences of the respondents are reflected in the analysis and reporting of research (Ahern, 1999). Each person’s values are the result of several different factors that include personality, culture and socioeconomic status; and in many forms of qualitative research, researchers are expected to make efforts to suppress their own values, to be able to describe respondents' life experiences more precisely. During the research process it was important to be aware of and to consider how my own gender as a researcher intersects with the lens through which data is generated. We do not know enough about how being a female researcher may impact the qualitative interview setting with fathers, but we can assume that this may be both a strength and a weakness. The evidence does suggest that men may be more likely to confide in women. In the field of family research, this can facilitate rather than inhibit the research (Davies & Hanna, 2021).

4.4 Methods

The research project has a combination of a phenomenological and hermeneutic approach with an explorative, descriptive and synthesising design. In studies I and II, new parents were interviewed, while in study III a qualitative meta-synthesis of nurses' perspectives on postnatal health care took place. Finally, the findings of the three studies are synthesised in the thesis, which is illustrated in Table 2.

Table 2 Overview of the study design

Studies	**Study I**	**Study II**	**Study III**
Aim	To describe new fathers' expectations of and experiences with municipal postnatal health care services	To describe parents' joint and individual experiences with public health nursing and child and family health centre services in the postnatal period	To integrate and synthesise knowledge of nurses' perspectives on municipal postnatal health care
Method			
- **Data collection**	Joint and individual interviews (1-2 and 6-8 weeks after birth)	Joint and individual interviews (1-2 and 6-8 weeks after birth)	Meta-synthesis of previous qualitative studies
- **Sample**	Purposive	Purposive	Purposive
- **Analysis**	Reflective Lifeworld Research approach (Dahlberg et al., 2008)	Reflective Lifeworld Research approach (Dahlberg et al., 2008)	Meta-ethnography (Noblit & Hare, 1988)
Participants	N = 10 fathers	N = 10 fathers N = 10 mothers	N =13 included studies
Thesis	Synthesis based on the findings in the three studies		

4.5 Studies I and II

4.5.1 Reflective lifeworld research approach

In studies I and II, the purpose was to gain a deeper insight into fathers' and parents' joint and individual expectations of and experiences with public health nursing and municipal postnatal healthcare. When designing the study, several different phenomenological methods were considered, such as grounded theory and ethnography. Reflective Lifeworld Research studies (RLR), as it is outlined by Dahlberg et. al (2008), was the methodological approach chosen for the two studies, as RLR is an open and flexible approach that seeks to describe and elucidate the lived world in a way that expands the understanding of human beings and human experience (Dahlberg et. al., 2008). RLR was also considered relevant because it is safely rooted in the phenomenological tradition, and is an approach created to meet the appeals from healthcare focusing on human existence (Dahlberg & Dahlberg, 2020).

The RLR approach is based on the epistemology of phenomenological and hermeneutical philosophy and the aim of RLR is to make the phenomenon of the study appear and to describe it as it is experienced by people (Dahlberg et al., 2008). This means taking account of the research participants' experience of reality and being phenomenon oriented. RLR is characterised by the methodological principles of openness, flexibility and bridling. Openness as a researcher is the genuine willingness to see, listen and understand. Openness and flexibility in lifeworld research thus means entering the world of a person, leaving behind one's expectations of what will be found, and having the capacity to be sensitive to and surprised by the unexpected, which is necessary to understand the phenomenon in a new way. The epoché and phenomenological reduction, also known as bracketing, are key elements in Husserl's philosophy of phenomenology (Zahavi, 2018). Epoché is Greek and means abstention and the term is used to capture the actions necessary to suspend the natural attitude of taken-for-granted beliefs and the attitude of science. So as not to understand the phenomenon too quickly and define what is still indefinite, Dahlberg et al. (2008) use the term “bridling”. This term covers not only an understanding of being aware of one’s own pre-understanding, but of the understanding as a whole during the entire research process. “Bridling” has helped me as a researcher to consciously direct my energy into the open attitude, allowing the phenomenon to present itself. Openness towards the material and searching for meanings without any preferences for theories or categories, has been important in the analysis process. Using the RLR approach, the essential structure of the phenomenon and its constituents is described in the two empirical studies. According to Dahlberg (2006), an essence can be understood as a phenomenon’s style, its way of being or the structure which makes the phenomenon that specific phenomenon.

4.5.2 Preparations for the study

According to The Research Council of Norway (2022), the primary objective of user participation is to ensure that the research is of genuine relevance and can be used in the best possible way. Patient and service user engagement is receiving increasing attention in health research. User participation means that end users of the research contribute at different stages of the research process. In this context, users are most often patients and relatives, but can also be healthcare professionals, decision-makers, or the general population. To ensure relevant and useful research and safeguard the democratic aspect of this research project, a parental couple (mother and father) with lived experiences from postnatal healthcare, a midwife and a PHN from two different CFHC services in the southwest of Norway, were invited into the project in the initial phase. There were two meetings with the parents in 2019 and one meeting with the healthcare personnel during the research process, also in 2019. They all contributed important knowledge in the initial phase of the study. The parents and healthcare professionals shared their own experiences as users and providers of the service, and they read through and gave input on information letters to the informants and the managers who contributed to the recruitment of informants. They also contributed valuable comments and input regarding the interview guide. In addition, findings from study I were presented and discussed with the father on Teams (due to the coronavirus pandemic), in autumn 2020.

4.5.3 Setting, participants and recruitment

All leaders of maternity care/CFHCs in the municipalities, and the head of the birth and maternity department at one of the hospitals in the relevant region, were contacted by email and asked to help with recruitment. Written information about the study was given, and a meeting with the ward manager at the hospital was held, in addition to verbal information about the study. The leaders informed relevant participants about the study and contacted me about parents who wanted to participate, and I then made appointments with the parents directly by phone. Before conducting the interviews, I repeated the information given about the study and that the parents could withdraw at any time.

To gain insight and in-depth understanding of the phenomenon, a purposive sampling strategy was used. This is a typical approach to sampling in qualitative research, and a range of different sampling strategies can be used (Dahlberg et al., 2008; Braun & Clarke, 2013). In this study, this involved selecting participants who would be able to provide "information-rich" data to analyse. Ten parental couples (ten mothers and ten fathers) participated in the study, and they were recruited with the help of midwives from the maternity ward at one hospital and midwives at one CFHC. Two couples were recruited by snowball sampling. The context of the studies is Norwegian public health nursing and CFHCs in municipalities in both urban and rural areas of the southwestern region of Norway. The inclusion criteria were couples who had recently become parents, as parents of different genders, mastering a Scandinavian language, and with mother and infant discharged from hospital within the third day after birth, without the need for additional follow-up, and parents planning to make use of CFHC services. The inclusion criteria are in line with Polit and Beck (2021) with regard to the transfer value of the findings. The parents chose the setting for the interviews, and they all chose their own homes. Conducting the interviews in the couples' homes meant that the parents felt comfortable and relaxed (Braun & Clarke, 2013), and it was easier for them to take care of the newborn baby (who was naturally also present) in their own home environment during the interview. None of the subjects withdrew after the agreement was signed. The recruitment process took place relatively quickly, and all the 30 interviews were collected in the period from October 2019 to March 2020.

4.5.4 Data collection – joint and individual interviews

In phenomenology, it is emphasised that language is the tool for all dialogue, in questioning and understanding, and thus language makes possible the interaction through which the lifeworld is shared (Dahlberg et al., 2008). Discourse and context were important to Gadamer (1960), who expressed how an understanding of the phenomenon cannot always be found solely in the words themselves, if they are isolated from their context. Hence, words could be seen as having a hermeneutic function by contributing to shedding light on the phenomenon being studied.

The data collection took place over a period of five months and all the parents were interviewed face-to-face. A semi-structured lifeworld interview was used, and the interviews were recorded as audio files and subsequently transcribed verbatim. Even though this was a time-consuming process, I chose to transcribe the interviews myself. As described by Kvale and Brinkmann (2017), transcribing the material taught me something about my own interview style, helped me gain a picture of the material as a whole and contributed to securing details that were important for the analysis.

Lifeworld research focuses on lived experiences and does not want preconceived answers (Dahlberg et al., 2008). To fulfil the purpose of establishing an open and reflective dialogue, the interviews were conducted with a focus on balancing between being structured and unstructured. To direct the interviewees' intentionality towards their lifeworld, their feelings and thoughts, the parents were asked open questions such as "can you please describe how you have experienced the first days at home with a new baby", "what expectations do you have of the postnatal health care?" and "what experiences do you have in relation to the follow-up you and your family have received from PHN and CFHC in the postnatal period?". To gain a deeper understanding, follow-up questions were asked, such as "can you please tell me more?" and "what has been important to you?".

Data was collected twice. First, as joint interviews with the parents after returning home from hospital (1 to 2 weeks after birth), and then as second individual interviews with the mothers and fathers separately when the postnatal period was over (6 to 8 weeks after birth). The main focus of the couple interview was the parents' expectations and experiences in the early postnatal phase, while for the individual interviews it was their experiences with the public health nursing and CFHC services. The two approaches complement each other in elucidating different aspects of the parents' experiences (Taylor & de Vocht, 2011) and conducting joint and individual interviews can both deepen and broaden the content of the data collected (Norlyk et al., 2016). The couple interviews can bring out different views on the topic and create a context in which meaning is formed, while the individual interviews provide space to open up and share information that one may not want to convey in the couple interview (Blaikie, 2010; Brottveit, 2018). Another reason for conducting two interviews was to learn about expectations and experiences during the postpartum period and to provide room for reflection for the parents between the interviews. This also gave me, as an interviewer, an opportunity to follow up topics that had been discussed in the couple interview (Whitehead, 2004). Lifeworld research depends on rich variation in data to be able to create a general structure of any kind (Dahlberg et al., 2008). The phenomenon under investigation directed the data gathering, while at the same time it was important to reflect on the informants' differences in age, culture, tradition, working experience and geographical area. Although the question of variation is more important than the question of number, the data material consisting of 30 rich interviews helped to ensure both depth and breadth in the material.

As mentioned, all parents chose their own homes as the setting for the interviews, which lasted between 10 and 60 minutes, with a mean duration of 35 minutes. In the joint interviews, some questions were for mutual reflection and others were directed at the mother or father. Some of the joint interviews were characterised by the mother being the most active and talkative, but there were also interviews in which the father's voice dominated. In these situations, I deliberately sought to include the other parent by asking them to elaborate on experiences related to the topic being discussed.

One of the individual interviews with a father was short and lasted only ten minutes. This father had not been in contact with either the family's PHN or the CFHC during the postnatal period and, as I see it, this experience of no contact can be seen as an important finding and shows that even short lifeworld interviews have the potential to contribute nuances to descriptions (Dahlberg et al., 2008). In all the joint interviews, the baby was present in the room during the interview. This to some extent affected the parents' attention and presence.

4.5.5 Analyses

The transcribed data from the interviews was analysed according to the RLR approach (Dahlberg et al., 2008). The analysis of lifeworld research is governed by some general principles that adhere to a tripartite structure described as a movement between the whole – the parts – and the whole. The movement is important to all understanding and by taking a “bridled” attitude (Dahlberg et al., 2008), I sought to be as open and reflective as possible towards the involved movements of the work. When analysing the transcribed research data for meaning, it was important to understand each part in terms of the whole and also to understand the whole in terms of its parts. According to Gadamer (2012/1960), this constant movement of understanding contributes to centrifugally expanding the unity of understood meanings. This hermeneutic “spiral” can help us understand the text on its own terms and the phenomenon being studied can fit into new contexts and be understood in new ways. As described by Dahlberg et al. (2008), this methodological principle can be understood as a general rule for understanding, and is valid for both phenomenological and hermeneutical research analysis. First, all the transcriptions from the joint and individual interviews were read several times to get a sense of the data as a whole. Then meaning units were identified and grouped together in clusters to develop a structure. The data analysis process is illustrated in Table 3.

Table 3 Example of the three phases of data analysis

Phase 1 Reading/rereading of transcripts		**Phase 2** Clusters of meaning	**Phase 3** Gathering clusters of meanings in patterns
Extract from interview	**Content**	**Meaning unit**	**Constituent**
“You are a bit blind when you go in there (CFHC), in relation to what is going to happen and how they do things” (IF5)	The father does not know what is going to happen when he enters the CFHC	Little information about the CFHC in advance means that fathers do not know what	Not knowing what to ask for

"I had no expectations. I was expecting follow-up, and I got it, but – well, it was not so much in my mind. It would have been nice to get a small brochure or leaflet about the CFHC offer, in addition to the website" (JF3)	The father has no expectations based on little information about the CFHC offer	the service can offer them	

Making clusters was a helpful intermediate "landing stage" in the analysis and after dwelling on and discussing with my supervisors, patterns of meaning emerged from considering how the clusters were related to each other. Then the clusters of meaning were re-read, and the process continued by being open and sensitive to the text and conducting a dialogue with it until a pattern appeared in the clusters. The essence of the phenomenon emerged gradually throughout the analysis process, followed by different meanings that constitute the essence. The essence can be described as the phenomenon's style or way of being (Dahlberg, 2008). To show some meaning nuances and descriptions from the data, quotes from the interviews were presented in the constituents.

4.6 Study III

4.6.1 Meta-ethnography

Study III is a metasynthesis of scrutinised peer-reviewed qualitative studies of municipal postnatal healthcare from the nurses' perspective. Metasynthesis was chosen because studies related to the phenomenon are scattered (Sandelowski et al., 2007) and no previous metasynthesis has been identified. Metasynthesis is a generic term for qualitative research of previous original qualitative research findings as data (Bondas et al., 2017).

The method chosen in this study is meta-ethnography developed by sociologists Noblit and Hare (1988) in the field of education and is an inductive and interpretive method. There is a growing interest in metasynthesis research of nursing, and meta-ethnography was chosen on the basis of its potential to provide a wider and more nuanced picture of the phenomenon studied and to contribute to the development of evidence-based care (Bondas & Hall, 2007).

By compiling all available research and translating the studies into one another, a synthesis can be constructed (Noblit & Hare, 1988). Being explicit about any assumptions made is vital and, as suggested by Noblit and Hare (1988), I created a list of the key metaphors, phrases, ideas and/or concepts and their relations used in each account and juxtaposed them. As described by Bondas et al. (2017), the studies can be combined so that one study can be presented in terms of another and they are directly comparable as reciprocal or analogous translations. The most common finding are analogous translations, which was also evident in study III. The studies that are included can be set against each other, allowing the reasons for one study's refutation of another to become visible; or the studies can be tied together by noting how one study informs and goes beyond another and represents a line of argument (Noblit & Hare, 1988; Bondas et al., 2017). The translations respect holism, protect the particular and enable comparison by maintaining the key metaphors and/or concepts of each account in relation to other central metaphors or concepts in that account (Bondas et al., 2017). The term *key metaphor* is used by Noblit and Hare (1988) and is similar to the terms of themes, perspectives and/or concepts. At the same time, when constructing a synthesis by translating multiple qualitative studies into each other's terms, it is important to consider that the analyst always translates the studies into their own world view. Hence, a meta-ethnography will inevitably partly be a product of the synthesiser (Noblit & Hare, 1988).

4.6.2 Systematic searches and quality assessment

I developed an extensive and thorough literature-search strategy based on the inclusion and exclusion criteria, with the assistance of an academic librarian, who also contributed her knowledge and experience regarding the choice of databases and search terms. To gain a broad picture of previous research of the topic and to ensure the inclusion of all good-quality articles, no time limitations were set for the search process. The inclusion criteria were peer-reviewed original qualitative studies focusing on nurses' (PHNs, nurses, midwives, or health visitors) perspectives on the municipal postnatal health care delivered. To ensure the quality of the search strategy, the searches were performed by the same academic librarian in June 2022, with an updated search in November 2022. The databases considered most appropriate for searches in the field of postnatal care and examples of search terms are illustrated in Table 4.

Table 4 Extract from search strategy

Databases	Cinahl, Medline, Embase, British Nursing Index, PsychInfo and Web of Science
MeSH terms	"Public Health Nurses", "Midwives", "Nurses"; "Community Health Nursing", "Home Nursing", "Postnatal Period", "Postnatal Care"; "Nurse Attitudes", "Midwife Attitudes", "Qualitative Studies+", "Focus Groups", "Semi-Structured Interview", "Narratives+"
Title and abstract	public health nurse*, midwi*, nurse*, health visitor*, postnatal*, post natal*, postpartum*, post partum*, municipal*, district*, communit*, home*; perspective*, experience*, attitude*, view*, qualitative stud*, qualitative research*, qualitative method*

Boolean search modes were used, combining search terms with OR and AND. A total of 1,642 articles were identified, and after removing duplicates and screening, 13 articles were included in the meta-ethnography (see PRISMA flow chart in paper III). The original qualitative studies considered suitable, according to the aim of the meta-ethnography, were assessed using the Critical Appraisal Skills Programme qualitative checklist (CASP) (2018). We had a discussion within the research team about one of the articles, in which there were identified weaknesses, such as a lack of adequate consideration of the relationship between researcher and participants and we were not able to identify whether ethical issues had been taken into consideration. Despite a reduced total score, we decided to include the study and found all the 13 studies included to be of high quality and to contribute valuable knowledge concerning the topic (Noblit & Hare, 1988).

4.6.3 Analysis and synthesis

The analysis process follows seven phases and is a systematic approach whereby a position is taken on the relationship between the studies, with assessment of whether they are analogous or stand in opposition to each other, and finally, synthesise a new whole (Noblit & Hare, 1988; France et al., 2018). The seven phases overlap and repeat as the synthesis proceeds: (1) getting started, (2) deciding what is relevant to the initial interest, (3) reading the studies, (4) translating the studies into one another, (6) synthesising translations and (7) expressing the synthesis. Synthesising in meta-ethnography refers to making a whole into something more than the parts alone imply (Noblit & Hare, 1988), and when analysing the translations, we moved beyond the findings of the individual studies to a second level of synthesis (Bondas & Hall, 2007; France et al., 2018). The interpretive process has the potential to create metaphors for a deeper understanding and, according to Noblit and Hare (1988), the use of metaphors is typical for line of argument synthesis and is used to convey deep structures and meanings in a text, which can create new understanding (Wiklund Gustin & Wagner, 2013).

By translating each primary study into each other, three themes and an overarching metaphor were developed, as shown in Table 5.

Table 5 Extract from translations to sub-themes, themes, and overarching metaphor

Translation	**Sub-themes**	**Themes**	**Overarching metaphor**
Humble and reserved, see themselves as guests in the families' homes. Being authentic/yourself and friendly. Multidimensional picture of the family's life situation. Listening and identifying individual needs and family resources.	Being caring and authentic Creating a picture of the family's situation during the home visit	Stretching human boundaries	**Being a "warrior" to care for the new family**
"Too early" and problematic discharges. Tight timeframe and increased postnatal care workload affects the quality of care. Choose the home or clinic for the first meeting. Discrepancy seen between nurses' expressed attitude and practice. Difficult to verbalise required competence and to measure the first postnatal visit and relationship building. Meets the mothers needs by listening and giving support.	Minimising home visits as a solution in managing increased workload Inviting parents' freedom of choice Listening is a competence, too	Stretching system boundaries	
Mother is seen as the expert. Partners (men) need an invitation to start parental identity process. Strong interest, but limited training and knowledge of LGBTQ issues. Inclusion of partners is needed, to try to create an inclusive environment.	Seeing mother as the expert and father as a bystander Striving to be open-minded	Stretching knowledge boundaries	

In line with Bondas and Hall (2007), it was important to communicate the research findings in a meaningful and comprehensible way, to make the findings assessable for parents, practitioners, politicians and relevant educators (nursing, public health nursing, midwifery), and by using a metaphor with an illustration to visualise the interpretation of the nurses as warriors (paper III), this might contribute to a deeper understanding of the phenomenon being studied.

4.6.4 Synthesis of the studies

By synthesising the findings of studies I-III, the findings can be lifted to a higher level of abstraction and thereby achieve the ambition of the thesis to strengthen the body of knowledge of public health nursing and contribute to the development of postnatal health care of the family. As shown in Table 1, the studies build on each other in terms of content and design, which enables a line of argument whereby one study illuminates and goes beyond the next (Noblit & Hare, 1988). When the studies are translated into one another together they can create a larger whole, based on the individual studies that are included (Noblit & Hare, 1988).

As the articles are quality assessed by peers in connection with publication, I chose not to undertake a quality assessment of the studies prior to the synthesis. I mainly followed the phases of meta-ethnographic synthesis (as described in Chapter 4.6.1) and chose to start with the studies in chronological order, starting with study I. Themes and metaphors were identified and compared and used as a basis to identify differences and similarities between the themes and to make new interpretations of the connection between the three studies. The articles had several overlapping themes, but unique themes also arose. The synthesis was not mechanical and linear, but involved a movement between parts and the whole, which can therefore be difficult to describe explicitly (France et al., 2014). After comparing and interpreting the articles, I assessed that the three sub-studies formed a line of argument which enabled a line of argument synthesis (Noblit & Hare, 1988; France et al., 2018). The process of translating, interpreting and reflecting helped me to develop the synthesis that represents a new overall understanding of the three articles' findings.

4.7 Methodological considerations

As qualitative researchers we are the main data collection instrument, which requires us to take steps to demonstrate the trustworthiness of the data (Polit & Beck, 2021). The main feature of these efforts can be described as the endeavour to confirm that the findings reflect the participants experiences and viewpoints rather than the researcher's perceptions. The quality of the research design and research process is discussed in this section.

4.7.1 Paper I and II

The RLR approach has been claimed to be an approach that is especially beneficial for practitioners, clinicians, caregivers and researchers in the health and social sciences, as it has the potential to illuminate the fundamental meaning structure of phenomena, thereby providing insight into the ontological nature of existential reality (Dahlberg et al., 2008; Dahlberg, 2019). The results in studies I and II are based on a variety of data and are presented as the studies' essence, with its constituents. In line with Dahlberg et al. (2008), I have chosen to use the terms objectivity, validity and generalisability to evaluate the scientific value of the two lifeworld research studies.

Objectivity and validity

Objectivity can be said to be a mechanism for avoiding bias and refers to the extent to which two different researchers can arrive at similar results or observations regarding concepts of interest (Polit & Beck, 2021). Objectivity is improved by efforts to establish that the data represents the study subjects' viewpoints and reflects the conditions of the enquiry, and not the researcher's perspectives or biases. As the basic concept of lifeworld research is to go to the things themselves, in this context objectivity and validity mean being open, susceptible and sensitive towards the phenomenon in focus. According to Dahlberg et al.

(2008), objectivity and validity can occur if the researcher approaches the phenomenon, as well as the research process as whole, in an open, “bridled” way. “Bridling” refers to the phenomenological process of bracketing, which is how the researcher demonstrates the validity of the data collection and analytical processes (Ahern, 1999). The process of bracketing is a recurring, reflexive journey that entails preparation, action, evaluation and feedback about the effectiveness of the process. The advantage of this process is that my energies as a researcher are used productively in seeking to understand the effects of my own experiences, rather than attempting to eliminate them. The term “bridling” was important throughout the research process and, according to Dahlberg et al. (2008), covers three aspects: firstly, the restraining of my pre-understanding (theories, personal beliefs and other assumptions) that might misguide understanding and limit the openness of the research. Secondly, the concept covers understanding as a whole, meaning to be disciplined while slowing down the process towards understanding. As a researcher, I have focused on not rushing to uncover the phenomenon and seeking to be aware of not making definite what is still indefinite. The third aspect of ‘bridling’ denotes adopting an open and alert attitude of actively waiting for the phenomenon to present itself. Initially, this was experienced as a challenge during the process of analysing the data in studies I and II, but by constantly being aware of slowing down the process, being open and flexible and having dialogue within the research team, the phenomenon under study was explored in a scientific way.

Generalisability

In addition to objectivity and validity, Dahlberg et al. (2008) claim that it must be possible to generalise all scientific research findings, for them to be valid for people other than those involved in the specific study. In research, generalisation refers to extending research results, based on a study of particular individuals, times, settings or institutions, to other individuals, times, settings or institutions then those studied (Polit & Beck, 2021). Lincoln and Guba (1985) discuss the concept of transferability as the extent to which qualitative research findings can be transferred to other settings, as an aspect of the trustworthiness of a study. According to Polit and Beck (2021), researchers can enhance generalisability by designing studies strong in validity and reliability. In the two studies, this was done by giving thought to the people for whom the results might be generalised, and then selecting participants, new mothers and fathers, who reflect the population of interest.

A challenge in qualitative research is to avoid presentation of fragmented results (such as categories and themes) without making clear what the results are part of, in favour of findings in the form of an essential meaning structure (Dahlberg, 2019). According to Husserl (1973/1939) an essence could be understood as a structure of essential characteristics of the phenomenon which make the phenomenon that specific phenomenon. An essential meaning structure of the phenomenon being studied is presented in studies I and II. In addition, descriptions of individual experiences and quotations from participants complete the view of the phenomenon, illuminating the phenomenon's variations. However, since essential meanings, as well as individual experiences, are contextual, an objective, valid and generalisable result should be considered to be an ongoing conversation which is never finished (Dahlberg, 2019).

4.7.2 Paper III

In study III, a meta-ethnography based on the original seven steps, as developed by Noblit and Hare (1988), was used. This is a systematic approach which synthesises data from multiple qualitative studies and is one of the approaches most utilised to enable new insights into patients' and healthcare professionals' experiences and perspectives. In line with Sandelowski and Barroso (2007), during the entire research process we were thinking of ways to optimise the validity of the meta-ethnography. As validity relates to the truth of the study, promoting valid study procedures and outcomes can be enhanced through descriptive, interpretive, theoretical, pragmatic and negotiated consensual validity (Sandelowski & Barroso, 2007; Bondas et al., 2017). Validity in metasynthesis is also discussed by Bondas and Hall (2007), who argue for an explicit validity concept in metasynthesis that also takes account of potential problems, such as the reliability of data retrieval, missing data, sampling bias, loss of information, glossing over of details and heterogeneity of quality. They also emphasise the benefits of including a librarian in the team, as specialists in literature retrieval are usually able to find more references than researchers can (Bondas & Hall, 2007).

To ensure and increase the transparency, trustworthiness and credibility of the meta-ethnography conducted, the eMERGe guidance was used (France et al., 2018). Support from two academic librarians, quality assessment of the studies included and the methodological expertise of the research team contributed to the increased credibility of the meta-ethnography.

4.8 Ethical considerations

There are several ethical issues to be considered when interviewing women and men who have just returned home from hospital with their newborn baby. As described by Dahlberg et al. (2008), lifeworld research can involve deep experiences of our existence and stir up emotions and memories that informants did not even know they had. Feelings such as anger, fear, anguish and happiness can also come to light during an interview. Lifeworld research has the opportunity to invite informants to express certain thoughts and ideas that are important to them, and this might be the very first time the interviewees had the opportunity to share these thoughts and feelings (Dahlberg et al., 2008). Kvale and Brinkmann (2017) describe the qualitative research interview as a professional conversation within an asymmetrical power relationship between the researcher and the person being interviewed. If a researcher is solely aware of the interview’s close personal interaction and open form of understanding, it can be easy to overlook this asymmetry that also exists in the lifeworld interview. For me it became important to reflect upon how the asymmetric relationship potentially influenced the interview setting and the production of knowledge. By writing down reflections and thoughts in my research diary after the interviews, I could later discuss them with my supervisors and gain deeper insights, which contributed to improving my interviewing skills.

It is not unusual for participants become distressed when opening up and discussing sensitive issues, and this can be managed by acknowledging the person's distress and allowing them to express it (Braun & Clarke, 2013). During the interviews the parents had the opportunity to take a comfort break or to feed the baby. I also experienced that some of the parents became emotional while talking about the birth and their experience in the first days at home with a newborn. As an interviewer I sought to be sensitive to their emotional expressions and focused on meeting the mothers and fathers with empathy and respect. When the interview situation was over, the parents were encouraged to contact their PHN or myself if they wanted to talk more about topics or experiences that came up during the interviews. All participants completed the interviews and described being interviewed, with the opportunity to share their thoughts and experiences, even though this had brought emotions to the surface, as a positive experience. Several participants highlighted that it felt meaningful to be able to contribute to research and service development.

The study was approved by the Regional Committee for Medical and Health Research Ethics (REK) (reg. no: 2019/7220) and by the Norwegian Centre for Research Data (NSD/SIKT) (project number: 420055). The application was approved with conditions regarding justification of the exclusion criteria that applied to 1) parents of the same gender; and 2) parents who did not live together. The information letter also had to be revised as the university's logo and the email address of the institution's data protection officer were missing, and the reference number for REK approval had to be entered. The conditions were accepted and a letter with reflection on the exclusion criteria was sent, in addition to a revised information letter that was in accordance with REK's comments. Our feedback highlighted, among other things, that we wanted to shed light on how the provision of postnatal health care meets the family's needs, and specifically whether the health service is able to meet fathers' expectations and needs. Reflections following REK's response led us to choose to remove the criterion that parents had to live together, as we agree that there may be parents who have children and who share care and follow-up of the child without living together. We wanted to be open and saw that this exclusion criterion could potentially contribute to narrower data material. Approvals and reflections on exclusion criteria are presented in Appendix I.

In line with the Helsinki Declaration (World Medical Association, 2013), the participants received both oral and written information about the aim of the study, anonymity and the confidentiality of any data given. They were assured of their right to withdraw from the study at any time without explanations or consequences, and the participants gave their written informed consent prior to the interviews. A data management plan was created in line with the requirements of the Research Council of Norway and the EU. The plan describes how the data was managed during the research project and after project completion. The data management plan contributes to the legal, structured and safe handling and storing of data.

5 Summary and synthesis of the findings

In the following section, a presentation of the findings from the three studies is summarised, followed by a synthesis of the findings across the studies. Further details can be found in the appended articles.

5.1 Study I

Going blindly into the women's world: a reflective lifeworld research study of fathers' expectations of and experiences with municipal postnatal healthcare services

The aim of the first study (paper I) was to describe the phenomenon of new fathers' expectations of and experiences with municipal postnatal healthcare services. A phenomenological reflective lifeworld research (RLR) approach was chosen, and ten fathers were interviewed twice during the postnatal period. The data was analysed to elucidate a meaning structure for the phenomenon and the essence of their expectations and experiences is described as *going blindly into the women's world.* The following constituents further describe the essential meaning structure: *Not knowing what to ask for, Feeling excluded, Seeking safety for the family* and *Longing for care*.

Not knowing what to ask for: A lack of information about postnatal care and what to expect from the PHN and CFHC service made it difficult to have any expectations in advance. *Feeling excluded:* Although parenthood was seen as a joint project by the fathers who also described being different fathers than the generations before them, a feeling of being excluded by the PHN and CFHC services was predominant and led to uncertainty concerning the extent to which postnatal care was a service offered to fathers, as well as mothers. The feeling of being excluded added to an image of a world *of* and *for* women. *Seeking safety for the family:* The sense of security was essential for the fathers in the initial phase at home and served as a necessary foundation when building a framework around the new family. To guarantee a feeling of security postnatally, an accessible and inclusive CFHC service was needed. Early home visits by PHN were described as a good experience, and receiving visits by competent professionals in a vulnerable transition phase was deemed a major strength. *Longing for care*: Feeling safe, included and equal was linked closely to care and the fathers appreciated the caring supervision by the PHN. The fathers described a desire to be acknowledged and taken care of, which underscores that fathers also need care during the postnatal period.

It is suggested that fathers' feelings of exclusion and inequality might be avoided by focusing on both the mother's and the father's individual follow-up needs and by regarding the newborn baby and the parents as a family unit to a greater extent.

5.2 Study II

Parents' experiences with public health nursing during the postnatal period: A reflective lifeworld research study

The aim of study II (paper II) was to describe parents' experiences with PHN and CFHC services postnatally and was based on a reflective lifeworld research (RLR) approach. By using joint and individual interviews, 10 mothers and 10 fathers were interviewed twice. The essence and the essential meaning of the phenomenon is characterised by the parents *longing to be seen and confirmed as unique individuals and as a family by the PHN when learning to care for their baby*. The essence of the phenomenon is expounded on and elaborated by its four constituents: *Feeling a bit skinless with an increased need for care, Missing a dialogue about parenthood and family, Home visit as a family experience on the parents' premises* and *Mother is the messenger.*

Feeling a bit skinless with an increased need for care: Having a baby was described by the parents as a joyful experience, while at the same time an increased need for both lay- and professional care became prominent. *Missing a dialogue about parenthood and family*: Having a child together created mutual dependence between the parents, and caring for the newborn, each other and older siblings was something the parents described as particularly important during the postnatal period. The perception of a missing family perspective became evident from the parents' reflections relating to their encounters with the PHN. Experiencing that the focus was directed mainly at mother and baby, the parents expressed a longing to be seen more as a unit, in which all family members played a role in 'the becoming of a new family'. *Home visit as a family experience on the parents' premises*: The home visit was perceived by the parents as concrete care and attention, and the establishment of contact with the PHN in their own home environment contributed to increased security. During the home visit, both parents could ask questions and receive evidence-based answers, which was emphasised as important by several mothers and fathers. *Mother is the messenger:* Even though most mothers described being satisfied with their relationship with the PHN and the care provided by the CFHC services, some of them expressed how they perceived that fathers were not given the same opportunities as mothers, and were not incorporated to the same extent in consultations concerning the baby. This finding was supported by statements from several fathers, who described feeling excluded by the PHN and CFHC services. They experienced how the flow of information and contact solely took place between the mother and the PHN. Some of them also expressed how they perceived that the CFHC was primarily a mother-child offer and that it became the mother's role to act as a messenger between the father and the PHN.

To meet the new parents' unique individual needs and concurrently recognise the family as a unit whereby the whole family's health and well-being are important for the parents and their baby, further development of postnatal healthcare is proposed.

5.3 Study III

Being a "warrior" to care for the new family – a meta-ethnography of nurses' perspectives on municipal postnatal healthcare

The purpose of study III (paper III) was to integrate and synthesise qualitative studies that illuminate and describe nurses' perspectives on municipal postnatal healthcare. The analysis followed the seven phases of Noblit and Hare, and the goal of this meta-ethnography was to expand the knowledge base from nurses' perspectives and to promote the health and well-being of the new family, thus the research question was: What are nurses' perspectives on the municipal postnatal healthcare? The sample comprised 13 articles displayed in a PRISMA flowchart. The studies included were conducted in Sweden (4), Ireland (2), Canada (2), the United Kingdom (1), Northern Ireland & the Republic of Ireland (1), Australia (1), Norway (1) and Finland (1).

The studies included revealed how nurses in the municipal postnatal healthcare setting described a stretching and pulling of boundaries related to providing the best possible care of the new families. The overarching metaphor *Being a "warrior" to care for the new family* was adopted and emerged as a result of a pattern identified in the translation process, where the caregivers' internal and external opportunities for caring were perceived as challenged and stretched. For the nurses, stretching the boundaries had the potential to contribute to good postnatal care, while at the same time it could also contribute to various challenges which, on the other hand, could weaken the quality of care. The overarching metaphor was accompanied by three main themes: *Stretching human boundaries, Stretching system boundaries* and *Stretching knowledge boundaries*.

By stretching their human boundaries, the nurses were able to connect and communicate with the family in a trustful and supportive way. The home visit was deemed invaluable, as the home environment contributed to facilitating the establishment of a caring relationship. System boundaries were often stretched, due to tight timeframes and a heavy workload in municipal postnatal health care, challenging the quality and continuity of care. By stretching their knowledge boundaries, the nurses' desire for more knowledge about the transition to parenthood of lesbian, gay, bisexual, transgendered and queer parents was evident, and a call for clearer policies and procedures related to enabling the inclusion of fathers and partners in psychosocial assessment and postnatal depression screening was revealed.

The themes reflect how nurses stretch boundaries to provide the best possible care during the postnatal period, while the overarching metaphor offers a deeper understanding of the nurses as "warriors" who were willing to go the extra mile for the new families. The result of this meta-ethnography suggests an increased focus on different family constellations and the inclusion of the father or non-birthing partner in both education and practice.

5.4 Synthesis of the findings across the studies

Inspired by Noblit and Hare (1988), the findings of the three studies are lifted to a higher level of abstraction. The results of the studies build on each other, which enables a line of argument synthesis in which one study illuminates and goes beyond the next (Noblit & Hare, 1988). Hence, they can be translated into one another to create a larger whole based on each individual study. A synthesis of the findings across the studies illustrates postnatal healthcare as it is experienced from the fathers', couples', and nurses' "world" (Figure 3).

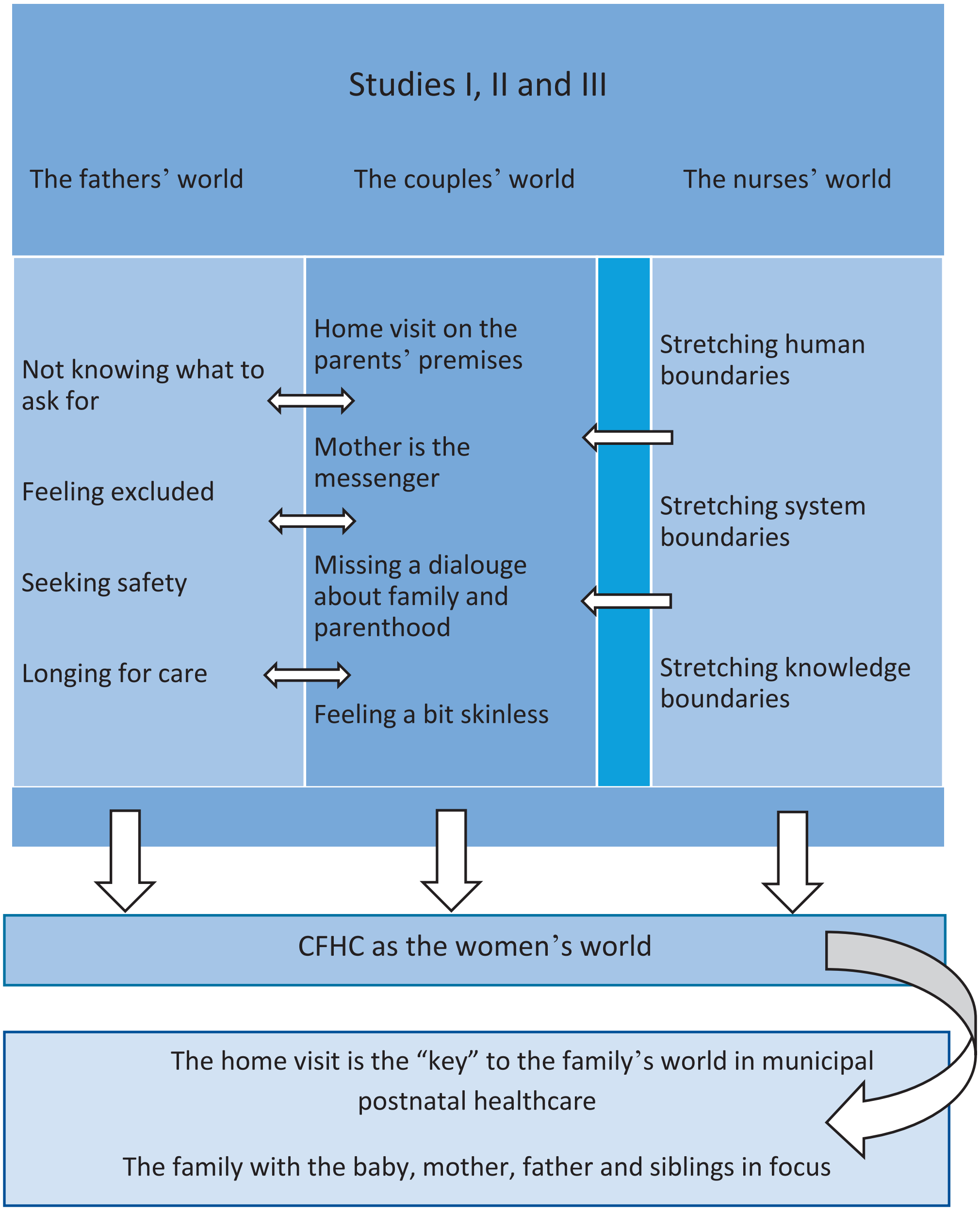


Figure 3 The home visit as the "key" to the new family's world

Seen from the fathers' world (study I), it is as if they are standing outside and looking into a world of which they are not part; while seen from the couples' world (study II), it is the mother's role to be a messenger between the father and the nurse, who seeks to see the whole family (study III).

The parents describe the postnatal period as a phase characterised by both joy and vulnerability, and one of the main findings of studies I and II is that being cared for while learning to care for the baby is pivotal for new mothers and fathers. The CFHC is experienced by the parents as "a women's world". A world in which mother and child are in focus, and where women meet women and their babies. It is also a world of which many fathers want to be a part and into which they are longing to be invited. Both parents regard their parenting as teamwork and would like continuous dialogue with the PHN on becoming parents, while learning to take care of their newborn, their relationship and themselves. This is not fulfilled in public health nursing, as the fathers feel excluded and do not know what to ask for, while mothers act as messengers. Even though nurses stretch their knowledge boundaries, seek to be open-minded and try to create an equal and inclusive environment for all parents, it is evident that partners are often excluded while the focus is on mother and baby.

Study III revealed that nurses are "warriors" who stretch boundaries to provide the best possible care for the parents and their baby, and that they are willing to "go the extra mile" for the families in the postnatal period. Nurses stand in a human, system and knowledge span to attain their goal; and within the perspectives of nurses, postnatal care is characterised by a continuous stretching and pulling of boundaries related to tight timeframes and an increased postnatal care workload. The nurses perceive the home visit as an entrance into the new family's lifeworld and, while striving to be good listeners, nurses stretch themselves towards understanding the parents' needs and lifeworld, so as to be able to support their process of getting to know parenthood.

The home visit provides for a shift in balancing public health nursing towards the whole family. The nurses see mother, father, baby and older siblings with different eyes than at the CFHC, revealing a more multidimensional picture of the family and their lifeworld in the family's home environment. During the initial home visit, nurses seek to create a reciprocal relationship and lay a foundation for the further collaboration with the family. Stretching towards each other as human beings is highlighted as an important act by both parents and nurses, and after the first home visit, most mothers and fathers are positive and hopeful about their further contact with the PHN. When the nurses enter the new parent's home "on their stocking soles" a shift in the power dynamic between caregiver and recipient is evident.

In all three studies, the home is seen as "the family's world". This is a world where parents and nurses meet on a more equal basis, relationships are established and the basis for further cooperation concerning the baby, each individual family member and the family as a whole is laid. The home visit is thus a key, or a link between the parents' and nurses' experience, which to a large extent forms the basis for the other intersecting findings in this thesis.

6 Discussion

This thesis contributes knowledge about how new parents and nurses experience and perceive municipal postnatal healthcare. Findings related to the phenomenon under study are highlighted in different ways in the three papers, based on studies I, II and III. Unique, shared experiences contribute to illuminate and describe the given phenomenon, based on the contextual variations that the perspectives of parents and nurses constitute. The developed synthesis of the findings forms the basis for the thesis' discussion and the findings that will be discussed in relation to previous research and the chosen theoretical perspectives. The discussion starts with postnatal healthcare as it is seen from the world of the fathers, couples and nurse's and then the home visit as the key to the new family's lifeworld is elaborated on and discussed, and finally, this section ends with some methodological reflections.

6.1 Postnatal healthcare seen from the father's world

The synthesis illuminates how fathers seem to be standing outside and looking into a world of which they are not part. The fathers in our study expressed how they were different fathers to the generations before them, and that most fathers today want to participate and be present in the child's life from the start. At the same time, and in line with the findings of Hodgson et al. (2021), fathers did not feel that they were met by PHN in the same way as mothers, when it came to care, support and follow-up, and the fathers also described how all information and communication with PHN and CFHC about the baby went through the mother, which contributed to a feeling of being left out and excluded.

Social changes and cultural contexts influence and shape fathering behaviour. Today, fathers take more responsibility for childcare duties and are more involved in family life (Chin et al., 2011; Shorey & Ang, 2019; Leahy-Warren et al., 2022). In their meta-synthesis, Shorey and Ang (2019) found that the relationship between father and infant is heavily influenced by the father's relationships with his spouse and family members, and work commitments were found to be an impediment to fathers' involvement. The literature search for this thesis revealed that many men feel excluded, as outsiders, when they are involved in the child health field and are often treated by healthcare professionals as "invisible", "bystanders" and "practical guys" (Steen et al., 2012; Wells, 2016; Shorey & Ang, 2019; Hodgeson et al., 2021).

Yet some of the fathers in our study (paper I), who felt that they knew the family's PHN, described that when they were invited into and included in the caring relationship, this contributed to security and mastering of the parental role, and was also perceived as being cared for. These findings are supported by Rautio (2012), who in her study of parents' experience of early support found that parents appreciated that their home visitor was a professional, but also had a personal way of working with the family. Listening, showing understanding and giving enough time to the parents were considered important, as well as including the father and taking his needs and expectations into consideration on an equal basis with those of the mother. Developing a trusting relationship with healthcare professionals is associated with parents' sense of security (Werner-Bierwich et al., 2018). These findings are in line with the results of Finlayson et al. (2023), who in their qualitative evidence synthesis found that fathers are more comfortable about discussing their concerns with healthcare professionals in their own homes, and are better able to develop a father-infant bond in these circumstances.

The caring relationship is an important concept within caring science (Eriksson, 2018; Bondas, 2003; Dahlberg & Segesten, 2010; Arman et al., 2015) and as stated by Eriksson, the caring relationship, or caring communion as she calls it, is something that ties together and unites human beings and gives caring its significance (Nyström et al., 2022).

The caring communion is also seen as a source of meaning and strength in caring, and for those joining in with a caring communion, it opens up and creates possibilities for the other. If only the mother is invited and welcomed into the communion, this deprives the father of the opportunity to participate in a "room" where there is potential to be transformed by the caring relation (Eriksson, 2018). Previous research (Barimani & Vikström, 2015; Werner-Bierwisch et al., 2018; Solberg et al., 2022; Sacks et al., 2022) supports our findings, since both parents have care needs in the postnatal period, and when a lack of focus on the fathers' well-being and significance for the baby is experienced, this can leave the fathers with a feeling of being unsupported, which again could lead to a sense of being helpless and unimportant.

In light of Erikson's concept of "suffering related to healthcare" (2018), fundamental characteristics of caring become visible when they are absent, and this concept might contribute to the discussion of how to improve healthcare services. Not being welcome, not being taken seriously, being blamed, and being subject to the exercise of power are different forms of suffering related to care (Nyström et al., 2022). In connection with our findings, there do not necessarily have to be "bad" intentions behind the fathers' experience of not being invited into the "women's world". As described by Dahlberg, this type of suffering can be understood as a lack of caring awareness from the organisation and caregiver, or in more philosophical terms, the caregiver is either immersed in routines or blind to the needs of the other (Arman et al., 2015).

6.2 Postnatal healthcare seen from the couple's world

The findings show that the CFHC appears to be "a women's world". Even though the parents describe having a baby as a joint project and both perceive the postnatal period as a phase filled with great joy and vulnerability, the CFHC is experienced as a world where mother and child are in focus and from which fathers feel excluded. The perception of the CFHC as a women's world can also be related to the environment and atmosphere at the CFHC, which has often been found to be female-dominated and may thereby unconsciously signal that this is an offer for mothers and children. As described above, these findings are in line with previous research (Wells, 2016; Hodgson et al., 2021; Finlayson et al., 2023). As a result, it becomes the mother's role to act as a messenger between the father and the nurse in municipal postnatal healthcare.

Having a child and becoming a parent is an existential experience. It is described as one of the most challenging transitions we, as human beings, experience in life (Nilsson et al., 2015; Wiklund et al., 2018). The transition has effects on many levels, such as emotionally, physically and mentally, which puts many couples under great strain. The postnatal period has been described by parents as living in a "new and overwhelming world" and previous research has described the time following birth as a period of relationship adjustment, with a shift in roles (Delicate et al., 2018; Valla et al., 2022). In this adjustment phase, the couple's priority is the baby, as they strive to develop their co-parenting relationship. Valla et al. (2022) found that satisfaction with the relationship is one of the most important factors for mothers' overall quality of life six months after birth. Figures from 2022 show that a total of around 25,000 children in Norway experienced their parents' separation (SSB, 2023), which underpins the importance of focusing on preventing couple breakups in public health nursing.

While longing to be seen as a family when learning to care for the newborn baby, the parents in our study would like continuous dialogue with the PHN on parenthood and family life. A report on the everyday lives of families with children in Norway (Egeland et al., 2021) shows that parents need more support in their parenting role, both as practical support and more guidance related to the couple relationship, which supports the findings of the thesis. The report also describes how families who live close to grandparents, and who have a good and close relationship, often get a lot of help and relief in everyday life. This is a significant finding in relation to public health nursing in terms of the importance of acquiring knowledge about families' individual need for care, support and follow-up, and in relation to offering equal services and preventing health inequalities. It is also important with regard to parents who do not live together and where the mother or father does not act as a messenger to ensure communication and information flow between the PHN and the other parent.

In this study (paper II), caring for each other, the baby and older siblings was described by the parents as very important. At the same time, support from family and close friends was also of significance to the new mothers and fathers. According to Eriksson (2018), caring takes place between human beings, such as family and friends, where the fundamental aim is to alleviate suffering and promote and protect health and life. In the theory of caritative caring, love, mercy and compassion are central concepts and constitute the foundation for all caring (Nyström et al., 2022). Sharing and listening in a caring fellowship and relationship enable compassion and kindness (Bergbom et al., 2021), which can be seen as a necessity for caring in the postnatal period. The importance of family support during the early days and weeks at home after birth was highlighted by both first-time and second-time parents in study II, which is also described in other research findings (Persson et al., 2010; Danbjørg et al., 2014). In a phase characterised by insecurity, care from both family members and healthcare professionals is described as important in the process of becoming a new family and when learning to care for the newborn baby (Wiklund et al., 2018).

Birth and the postpartum period constitute a complex life event not only for the birthing woman, but also for her partner (Bondas, 2003). Having a child brings changes for both the individual parent and for family life, with every new baby (Bondas, 2003; Shaw et al., 2006; Sacks et al., 2022). Each time a baby enters the world, a new family is born, and the parents need different kinds of communion to support them in establishing the unique new family unit (Bondas, 2003). According to Bondas, there are three types of caring relationship wished for by women in the childbearing context: the family communion, the interpersonal communion and the professional caring communion (Bondas, 2003). Some of the parents in our study described a lack of caring and support from their closest family and relatives. These parents highlighted the importance of municipal postnatal healthcare and described how the CFHC contributed to security and network building with other parents. This is supported by Alstveit et al. (2010), who found that the social relationship between first-time mothers seemed to be the most significant type of relationship during their maternity leave. This finding underscores the importance of the peer support groups for new parents arranged by PHN at the CFHC, to strengthen their social relations and their confidence in parenting (Alstveit et al., 2010; Glavin et al., 2016). Today, changes in society and migration are contributing to reshaping families and transforming traditional family structures. which, in addition to early discharge, contributes to new parents' increased need for practical support, monitoring and care from qualified healthcare professionals (Kurth et al., 2016; Sacks et al., 2022).

Early discharge requires an individualised and available healthcare system, to respond to the new parents' questions and concerns during the postnatal period and, as found by Danbjørg et al. (2014), families might experience a barrier when attempting to contact healthcare professionals, so that they instead consult the internet or their private network. This finding contributes to the discussion of whether the follow-up support needs of new families could be met through new forms of communication, such as evidence-based information knowledge bases and online communication (Danbjørg et al., 2014; Finlayson et al., 2023). This might be particularly important for parents who do not live together, or when the father (or mother) lives or works far away from the child.

6.3 Postnatal healthcare seen from the nurses' world

As shown in study III (paper III), nurses were continuously stretching boundaries to provide the best possible care for the new families. Although the metaphor of being a "warrior" denotes the nurse's willingness to go the extra mile for the mothers, fathers and babies, a heavy workload and a lack of resources negatively affected the quality of their work. The nurses also described how they needed more knowledge and time for reflection, while also calling for clearer guidelines and policy documents that could contribute to more equalised healthcare provision for parents, regardless of gender. Revising documents and forms to include a variety of family constellations might help guide healthcare professionals (Engström et al., 2021). Furthermore, healthcare professionals, such as PHNs and midwives, need to create an atmosphere that helps and encourages both parents to participate in CFHC care (Hammarlund et al., 2015; Finlayson et al., 2023).

While seeking to provide the best possible care, nurses stand in a human, system and knowledge span, to attain their goal. This thesis illuminates how nurses stretch their human boundaries towards a reciprocal and caring relationship with the family and how they perceive the home environment as a significant and invaluable precondition in this process. This view is supported by WHO, which recommends home visits during the postnatal period across all care settings (WHO, 2022). According to the nurses in this study, the home visit is experienced as an entrance into the new family's lifeworld and, while seeking to be good listeners, nurses stretch themselves towards understanding the parents' needs and lifeworld, so as to be able to support their process of getting to know parenthood.

In a qualitative study of maternal needs following childbirth, Slomian et al. (2017) found that healthcare professionals and mothers had very differing opinions on what new mothers needed after childbirth. The healthcare professionals believed that the mothers had received enough information about the time after birth and that they only needed to adapt to the new situation, while the mothers felt that they lacked support and were left to fend for themselves. In the same study, it was revealed that some of the healthcare professionals seemed to be aware of the pressure for discharge from hospital and that mothers might experience “being lost” after childbirth, but they thought that this mostly concerned disadvantaged women. But what became evident was that this experience was shared by the majority of the women, regardless of their social background. These findings reveal the importance of listening and providing individually adapted support and care during the postnatal period.

In accordance with the Nordic caring tradition and the basic consideration of the “patient’s world” (Arman et al., 2015), the lifeworld of the new family is not only perceived as a world of vulnerability and suffering, but is also seen as a world of well-being and development in healthcare. When entering the family’s home, a broader and more multidimensional picture of the parents’ lifeworld is displayed. When they are open to the lifeworlds of the unique and individual families, the PHNs can listen to their stories, touch and be touched without avoiding the ambiguities of existence (Dahlberg et al., 2009). Hence, public health nursing and caring led by lifeworld knowledge can lead to mothers and fathers feeling more deeply acknowledged in terms of both their vulnerabilities and opportunities (Rydström et al., 2021). Taking the parents’ perspective enables the development of the skill to give “caring care”, represented by a will and an effort to alleviate the new mothers’ or fathers’ suffering and to promote health (Arman et al., 2015).

6.4 The home visit as the key to the new family's lifeworld

On translating the three studies into each other in the synthesis, I found that the home can be perceived as "the family's world" from the perspectives of both the parents and the nurses. One of the main findings in this thesis is the significance of the home visit in the initial postnatal period, which is in line with previous research (Aune et al., 2018; Walker et al., 2019; Johansson et al., 2019). The family's home and lifeworld are emphasised as a good starting point for communication and the best place to be when laying a foundation for further collaboration in the early days of the postnatal period. The home visit was described by the parents in our study (papers I and II) as a family experience, and some of the fathers highlighted that this contributed to enhanced safety and lowered the threshold for future help-seeking. The parents perceived that the home visit and the encounter with the PHN in their own home represented something different to staying at the hospital of birth or having a consultation at the CFHC. In the home, previous research has shown that fathers in particular feel more confident and experience that they can take responsibility for their family, which contrasts with their experience at the hospital, into which many fathers do not feel invited to take part in caring for their baby (Steen et al., 2012; Nilsson et al., 2015; Hodgson et al., 2021).

According to Erikson's theory of caritative caring (2018), true caring is closely linked to compassion, and the core of caring is based on the foundation of faith, hope and love, which allows for tending, playing and learning. In the light of caritative caring, the findings of this thesis mirror the importance of being invited into a caring fellowship, where sharing and listening are central concepts in "caring care". Early discharge enhances the family's opportunity of being together in their homes, but the process of becoming a parent might be influenced positively or negatively, depending on the postnatal care (Nilsson et al., 2015). Both competence and confidence in parenting already begin in the first days and weeks of the baby’s life, and postnatal care problems might result in dissatisfaction, anxiety and unmet needs (Zadoroznyj, et al., 2015). The care offered by PHN or the midwife in the initial postnatal phase must be sensitive to the needs of the mother and the new family, by providing information, advice and support, while at the same time empowering the parents’ confidence in their parenting skills. Experiencing continuity of care, being taken seriously and being given individually adapted care are all important for new mothers and fathers (Wiklund et al., 2018).

The findings in this thesis show that a shift in the power balance became evident in the home environment, and when the PHN entered “the family’s world”, the parents experienced concrete care and attention, felt more active and perceived being met more on their own terms. These findings are supported by Aston et al., (2015) who found that building supportive relationships that were friendly, non-judgemental and fostered trust, was essential. What mothers and fathers need in order to feel secure in the postnatal period might be individual and culture-specific, which calls for targeted communication and individually adapted care and support. In a study of home-based midwifery care, Thies-Lagergren and Johansson (2023) found that the home visit was experienced as an occasion when the family could get well-adapted practical help and ask questions more freely. This kind of home-based postnatal care concept was perceived as a flexible and practical solution for the whole family, and the peace and quiet which the home environment represented were highlighted as important. On the other hand, and as discussed in paper III, it is important to balance closeness and distance, allowing parents to have faith in their own resources and develop parental self-confidence. Creating an inclusive and inviting environment for both mothers and fathers within the framework of the CFHC is also important, as well as safeguarding the parents’ right to decide for themselves on the arena for encountering the PHN during the postnatal period.

The home and the feeling of being at home are of significance to human beings' health and well-being (Hilli & Eriksson, 2019). When investigating the concept of *home* as ethos in caring, Hilli and Eriksson (2019) found that home, or the room where people meet, can be an abstract space or a physical place. The home can be seen as a sheltered place to which people can withdraw, to experience peace and privacy, as a place that offers freedom, but it can also represent a place where the special atmosphere is lost, leading to a feeling of homelessness. As human beings we have an inner desire to create our being, and how we live in our home, which is characterised by its atmosphere and culture and can be seen as an ongoing process in which fellowship is important (Hilli & Eriksson, 2019). As shown in this thesis, previous research shows that new parents need care, support and guidance in the postnatal period (Finlayson et al., 2020) and home visits are a supportive postnatal care strategy to meet the needs of the family with a newborn, after their discharge from hospital. In Denmark, since 1937 health visitors have visited all new families in their homes, irrespective of risks, and the content and number of home visits have been influenced by the health visitor's assessment of the mothers' individual needs (Kronborg et al., 2012). The high acceptance of home visits among new families shows that this is an attractive health promotion initiative and an essential low-technology tool that can be used at low cost in most settings (Kronborg et al., 2012; Yonemoto et al., 2021).

To achieve WHO's goal of a positive postnatal experience, it is stated that women, newborn babies, partners and families must receive information and reassurance, delivered in a consistent manner by motivated health workers, and within resourced and flexible health systems (WHO, 2022). As the findings in this thesis have illuminated, there is still more work to be done in offering municipal postnatal healthcare that has greater focus on the father/partner and the new family as a unit. Finlayson et al. (2023) propose that adopting a more inclusive approach, incorporating family-centred models of care in addition to more father-focused information and flexible contact opportunities, might contribute to enhancing the engagement of fathers in postnatal care services.

Family-centred care (FCC) has been suggested as a model with potential to improve postnatal care for mothers and their partners (Wiklund et al., 2018). FCC is a concept that emphasises how a child's healthcare should be planned and customised to fit the whole family (Shields et al., 2006). The following definition of FCC is often mentioned:

> "Family-centred care is a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person, and in which all the family members are recognised as care recipients" (Shields et al., 2006).

FCC is described as multidimensional, including "collaborative relationship, effective communication, respectful care, holistic perspective, individualised care, inter-professional coordination, self-awareness, empowerment, family as unit of care, interpersonal relationships, cultural knowledge, and cultural skills" (Lor et al., 2016).

In paper I, fathers' experience of having received little or no advance information about the CFHC offers in the postnatal period was described by a father as going blindly, and contributed to a stressful first encounter with the service. This is in line with the findings of an integrative review of support for fathers of preterm infants in early parenthood (Holm et al., 2022), which showed the importance of written and oral information in the early postnatal period in order to reduce stress and increase fathering ability, in addition to the necessity of collaboration and participation. The same study illustrates that there are fathers who do not feel they are sufficiently involved in infant care in the neonatal intensive care unit (NICU), indicating a further need for greater focus on the father and updated clinical practices, which resonates with the findings of this thesis. Even though most FCC research has focused on unwell children in hospital or community settings (Cohrssen et al., 2010) a study of FCC in universal, community-based, maternal, child and family health services (Ridgway et al., 2021) shows that FCC is a model that also fits well with the framework of childbearing and postnatal healthcare. At the same time, it is important not to overlook the child perspective when discussing babies and very young children within an FCC framework. The individual baby must be respected as a separate actor with their own rights, but still dependent on and close to the interests of the family (Coyne et al., 2018).

6.5 Methodological reflections

In this section I will discuss some methodological issues adding to the methodological considerations in the method chapter as well as some strengths and limitations of this thesis.

All research methods have their strengths and limitations (Polit & Beck, 2021). The thesis research design is shaped primarily based on the purpose and research questions, which in turn are influenced by our preconceptions, horizon of understanding, existing literature and data. On designing the study, we decided that the research questions could best be answered by using different data collection strategies (Richards & Morse, 2012). After discussing different strategies, we agreed that relying on one technique might produce homogeneous data, without providing sufficient sources of understanding and ways of looking at the phenomenon. We acknowledge that the nursing discipline needs methodological strategies that will enhance researchers' efforts to describe the complexity of human response to illness and health care situations. In recognition of this need, there is a growing emphasis on combining methods in a study, a practice often referred to as triangulation (Gerrish et al., 2015). According to Polit and Beck (2021), triangulation in a qualitative study might involve seeking to reveal the complexity of a phenomenon by using multiple means of data collection to converge on the truth. By using a twofold research design, joint and individual interviews, and meta-ethnography, we decided that we could best access the accounts of perspectives and experiences required by our topic, best weigh the different versions of “reality” and, finally, also best describe them. It is also considered a strength that the studies are based on three different perspectives.

By using a combination of joint and individual interviews in studies I and II, the parents were given the opportunity to discuss, co-create and individually reflect on the interview topics. I consider this to be a strength of the thesis and that this multi-level approach contributed to gaining a broader picture of the mothers’ and fathers’ individual and joint lived experiences. In line with Taylor and de Vocht (2011) we have experienced that combining individual and couple perspectives has resulted in a broader picture of the phenomenon and, as a result, it has perhaps contributed to reveal more aspects of “truth”. The presence of a partner has the potential to both limit and enhance the richness of the data collected. Although many of the joint interview settings consisted of sequences of exciting discussions and reflections between the parents, it might be considered a limitation that some of the mothers were the most talkative and periodically dominated. In retrospect, I see that these interviews might have been coloured by the mother's experiences. On the other hand, the subsequent individual interview became a new opportunity for the fathers to share their own lived experiences of the phenomenon.

I chose to carry out study III at the very end of my doctoral project because I considered it beneficial to avoid the results of the meta-ethnography influencing my preconception and openness in the two lifeworld studies. As a researcher with an insider perspective, the RLR approach has been helpful in adopting an open and reflexive attitude throughout the entire research process. Practicing “bridling” and deliberately slowing down the evolving understanding in order to let the phenomenon show itself has been important (Dahlberg et al., 2008). The RLR approach has also contributed to a new and wider understanding of descriptive and interpretive approaches in empirical research, by arguing that phenomenology and hermeneutics can be understood as no separate magnitudes (Dahlberg & Dahlberg, 2019). When moving from a descriptive (studies I and II) to an interpretive approach (study III), I strove to maintain the bridled attitude to be as open as possible to the phenomenon. When translating the studies into one another, the interpretive explanation made it possible to retain the uniqueness of the primary findings even when synthesised (Bondas et al., 2017).

7 Conclusion

This thesis provides new and expanded knowledge of municipal postnatal healthcare as it is experienced by parents and nurses, and contributes knowledge of what is important for new mothers and fathers in public health nursing. Having a child and becoming a parent is described as an existential experience which represents great changes at both individual, couple and family level. Greater vulnerability becomes prominent in the initial postnatal period, described as a journey through the physical and psychological, from chaos to stabilisation and, finally, normality.

In this thesis, it is established that the CFHC appears as “a women’s world”. Even though both parents describe having a baby as a joint, challenging experience, the CFHC is perceived as a world in which mother and child are in focus and from which fathers feel excluded. The fathers express that they are a new generation of fathers who are actively involved in the child’s life from the start and who expect to be regarded as an equal parent and caregiver within the child health field. On experiencing a lack of invitation and communication between the PHN and father about the baby’s health and development, it becomes the mother’s role to act as a messenger.

The postnatal period is experienced as an overwhelming phase which requires adjustments to the couple's relationship. In this phase characterised by both joy and vulnerability, the parents are longing to be seen as a family as they learn to care for their newborn baby and wish for continuous dialogue with the PHN on parenthood and family life. Despite tight timeframes and a heavy workload, nurses are stretching their boundaries to care for the new family in the postnatal period, and to achieve their goal to provide the best possible care. The nurses are “willing to go the extra mile” and seek to establish a reciprocal and caring relationship with the new parents.

The home is perceived as “the family’s world” and the significance of the initial postnatal home visit and the establishment of a caring fellowship are highlighted by both the parents and nurses. A shift in the power balance between the nurse and the parents becomes evident in the home environment, which means that care and support are experienced more on the family’s terms.

7.1 Implications for practice

The knowledge made visible through this thesis can contribute to reflections related to the existing practice and education of PHNs and midwives, and form the basis for new research questions and hypotheses that, in turn, can be explored, with the aim of contributing to improving practice. There is need for a more inclusive municipal postnatal healthcare service and one important suggestion is that healthcare professionals working within the field of childbearing and child healthcare should increase their awareness of the importance of their role and responsibility in including fathers and same-sex parents. Inclusive postnatal healthcare is necessary to safeguard the parents’ individual needs for care and support, and to ensure that the baby’s unique need for care and protection is viewed in the light of the family as a unit important for the health, development and well-being of the baby.

Healthcare managers play an essential role in facilitating PHNs’ and midwives’ involvement of fathers (or the non-birthing parent). In accordance with this thesis’ findings, it is suggested that they prioritise putting more family-centred and individually adapted postnatal care on the agenda and motivating their employees to improve their practice of paternal inclusion. The healthcare managers must also contribute to ensuring that healthcare professionals working within childbearing and postnatal healthcare have the staffing and expertise necessary to deliver a high-quality service offering inclusive and flexible contact opportunities for the new family.

Furthermore, and as emphasised in this thesis, the home visit is perceived to be an important way into the new family's lifeworld, which contributes to laying a good foundation for the care, communication and relationship building between the parents and the PHN. When managers and PHNs plan the postnatal follow-up for new babies and their families, this knowledge should be considered an important element of the argument not to reduce home visits based on financial incentives, but rather to assess whether this is a method that could be used to a greater extent, due to its health-promoting potential.

In this thesis, the findings show that the CFHC appears as "a women's world". These findings may provide important information to healthcare managers and healthcare professionals about the significance of the atmosphere and environment at the clinic. To meet today's diversity trend in relation to family constellations and parenting, it is suggested to design waiting rooms and offices to appear more gender-neutral and inclusive, thereby avoiding signalling that mothers belong there more than fathers. The "women's world" also refers to a world in which the mother and child are in focus and from which fathers feel left out, which can be seen as one of the most important findings to help develop municipal postnatal healthcare. On moving from a "women's world" towards a more "family-oriented world", it is suggested that we should strive for an even more flexible and accessible service, with extended opening hours, provision of groups and networking for fathers and new families, and new ways of communicating in the postnatal period (invitation to both parents, information sharing, online consultation, chat function).

7.2 Health policy and educational implications

This thesis highlights the importance of providing municipal postnatal healthcare that adheres to the requirements and recommendations, based on legislation, regulations and evidence-based standards. To meet these requirements, resourced and flexible healthcare systems are needed. As found in study III, one of the biggest threats to the quality and continuity of postnatal care is a heavy workload as a result of early discharge and limited municipal resources. As concluded in study III: *Being a warrior pushing and stretching system boundaries while striving to care for the new families puts the nurses at risk of being overstretched*.

Clearer policies and procedures to promote the inclusion of fathers and non-birthing parents in postnatal healthcare are suggested. To ensure equal and individually adapted care, based on the whole family's need for support and follow-up in the postpartum period, stronger recommendations in the national guidelines are suggested. Family-centred care (FCC) represents a model with the potential to improve postnatal care for the new family.

The experiences, perspectives and challenges raised in this thesis also have implications for the education of healthcare professionals such as PHNs and midwives. Contributing to the body of knowledge, this thesis has the potential to enhance further development of the education of these healthcare professionals by focusing on the importance of creating a relationship with both parents, and developing knowledge and skills by applying home visits as an essential method in postnatal healthcare.

Our study of nurses' perspectives on municipal postnatal healthcare revealed a desire for more knowledge about LGBTQ parents' transition to parenthood and displayed challenges related to acknowledging and strengthening same-sex parents in their different parental roles. One of the studies included in study III described how this topic was lacking in both nursing and midwifery education programmes. These findings reveal the significance of discussing and reflecting on topics and ethical issues that reflect the society we live in today, as well as the importance of practice in creating caring dialogues and caring relations in both education and practice.

7.3 Implications for future research

The findings of this thesis show that further research is needed to increase knowledge in the field of postnatal healthcare. The thesis has shed light on the experiences of parents without healthcare challenges in the encounter with PHN and CFHC services. As suggested in papers I and II, further research is needed to deepen our knowledge of multicultural fathers' and parents' experiences, and the experience of parents with additional follow-up needs in terms of municipal postnatal healthcare. More knowledge of how non-traditional families, such as same-sex mothers and LGBTQ parents, experience public health nursing and the CFHC services is also suggested.

As the findings in the three studies indicate, future research should explore how PHNs and midwives can include fathers and non-birthing parents in psychosocial assessments and depression screening. Knowledge of these topics is important to safeguard parents' mental health and well-being at a vulnerable time, which in turn will benefit the child, the family and society as a whole. To further develop municipal postnatal healthcare, it would also be beneficial to study PHNs' and parents' experience with group-based vs. individual CFHC offers in the postnatal period.

Through the identification of previous research during the work on the studies and the thesis, it became clear that research in this field is characterised by a gender imbalance. This might not be unexpected in view of the topic, but as this thesis shows, there is a need for more research related to fathers' and non-birthing parents' experience with postnatal care, which also calls for greater gender diversity among researchers dealing with this topic.

References

Actis. (2023). *Helsesykepleiernes arbeidshverdag* [*The public health nurses' everyday working life*]. Rapport. (In Norwegian).. https://actis.no/images/Rapport_Helsesykepleiere_endelig-versjon-komprimert-for-nett.pdf

Ahern, K. J. (1999). Ten Tips for Reflexive Bracketing. *Qualitative Health Research*, *9*(3), 407–411. https://doi.org/10.1177/104973239900900309

Alsaigh, R., & Coyne, I. (2021). Doing a Hermeneutic Phenomenology Research Underpinned by Gadamer's Philosophy: A Framework to Facilitate Data Analysis. *International Journal of Qualitative Methods*, *20*, 16094069211047820. https://doi.org/10.1177/16094069211047820

Alstveit, M., Severinsson, E., & Karlsen, B. (2010). Obtaining confirmation through social relationships: Norwegian first-time mothers' experiences while on maternity leave. *Nursing & Health Sciences*, *12*(1), 113–118. https://doi.org/10.1111/j.1442-2018.2009.00508.x

Andersen, R., Laholt, H., & Clancy, A. (2022). Hva gjør en helsesykepleier? [What does a public health nurse do?]. *Sykepleien*, *88781*, e-88781. (In Norwegian). https://doi.org/10.4220/Sykepleiens.2022.88781

André, B. (2017). Omsorg i sykepleien med en helsefremmende tilnærming [Care in nursing with a health promoting approach]. *Klinisk Sygepleje*, *31*(1), 60–72. (In Norwegian). https://doi.org/10.18261/issn.1903-2285-2017-01-06

Appelgren Engström, H., Häggström-Nordin, E., Borneskog, C., & Almqvist, A.-L. (2019). Mothers in same-sex relationships—Striving for equal parenthood: A grounded theory study. *Journal of Clinical Nursing*, *28*(19–20), 3700–3709. https://doi.org/10.1111/jocn.14971

Arman, M., Ranheim, A., Rydenlund, K., Rytterström, P., & Rehnsfeldt, A. (2015). The Nordic Tradition of Caring Science: The Works of Three Theorists. *Nursing Science Quarterly*. https://doi.org/10.1177/0894318415599220

Askelsdottir, B., Jonge, W. L., Edman, G., & Wiklund, I. (2013). Home care after early discharge: Impact on healthy mothers and newborns. *Midwifery*, *29*(8), 927–934. https://doi.org/10.1016/j.midw.2012.11.001

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., MacLeod, E., & Randel, P. (2015). The Power of Relationships: Exploring How Public Health Nurses Support Mothers and Families During Postpartum Home Visits. *Journal of Family Nursing*, *21*(1), 11–34. https://doi.org/10.1177/1074840714561524

Aune, I., Dahlberg, U., & Haugan, G. (2018). Health-promoting influences among Norwegian women following early postnatal home visit by a midwife. *Nordic Journal of Nursing Research*, *38*(4), 177–186. https://doi.org/10.1177/2057158517733244

Bäckström, C., Kåreholt, I., Thorstensson, S., Golsäter, M., & Mårtensson, L. B. (2018). Quality of couple relationship among first-time mothers and partners, during pregnancy and the first six months of parenthood. *Sexual & Reproductive Healthcare*, *17*, 56–64. https://doi.org/10.1016/j.srhc.2018.07.001

Baldwin, S., Malone, M., Sandall, J., & Bick, D. (2018). Mental health and wellbeing during the transition to fatherhood: A systematic review of first time fathers' experiences. *JBI Evidence Synthesis*, *16*(11), 2118. https://doi.org/10.11124/JBISRIR-2017-003773

Barimani, M., & Vikström, A. (2015). Successful early postpartum support linked to management, informational, and relational continuity. *Midwifery*, *31*(8), 811–817. https://doi.org/10.1016/j.midw.2015.04.009

Barimani, M., Vikström, A., Rosander, M., Forslund Frykedal, K., & Berlin, A. (2017). Facilitating and inhibiting factors in transition to parenthood – ways in which health professionals can support parents. *Scandinavian Journal of Caring Sciences*, *31*(3), 537–546. https://doi.org/10.1111/scs.12367

Bengtsson, J. (1988). *Sammanflätningar* [I*ntertwining. Husserl's and Merleau-Ponty's phenomenology*]. *Husserls och Merleau-Pontys fenomenologi*. Bokförlaget Daidalos. (In Swedish).

Bergbom, I., Nåden, D., & Nyström, L. (2022). Katie Eriksson’s caring theories. Part 1. The caritative caring theory, the multidimensional health theory and the theory of human suffering. *Scandinavian Journal of Caring Sciences*, *36*(3), 782–790. https://doi.org/10.1111/scs.13036

Bergbom, I., Nyström, L., & Nåden, D. (2022). Katie Erikson’s caring theories. Part 2. The theory of caritative caring ethics and the theory of evidence. *Scandinavian Journal of Caring Sciences*, *36*(4), 1251–1258. https://doi.org/10.1111/scs.13098

Berger, R. (2015). Now I see it, now I don’t: Researcher’s position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Black, F. (2023). Fathers’ self-reported wellbeing in the first postnatal year: How can health visitors help? *Journal of Health Visiting*, *11*(2), 62–70. https://doi.org/10.12968/johv.2023.11.2.62

Blaikie, N. (2010). *Designing social research: The logic of anticipation* (2nd ed.). Polity Press.

Bondas, T. (2003). *Olika former av vårdande gemenskap* [*Different forms of caring community*]. *Gryning II, Klinisk vårdvetenskap* (K. Eriksson & U. Å. Lindström, Eds.). Institutionen för vårdvetenskap, Åbo Akademi. (In Swedish).

Bondas, T., & Hall, E. O. C. (2007). Challenges in Approaching Metasynthesis Research. *Qualitative Health Research*, *17*(1), 113–121. https://doi.org/10.1177/1049732306295879

Bondas, T., Hall, E. O. C., & Wikberg, A. (2017). *Research Methods in Health: Foundations for evidence-based practice* (Liamputtong, P., Ed.). Oxford University Press.

Bondas-Salonen T. (1998). New mothers' experiences of postpartum care—A phenomenological follow-up study. *Journal of Clinical Nursing (Wiley-Blackwell)*, *7*(2), 165–174. c8h. https://doi.org/10.1111/j.1365-2702.1998.00138.x

Braun, V & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Brottveit, G. (red.). (2018). *Vitenskapsteori og kvalitative forskningsmetoder: Om å arbeide forskningsrelatert* [*Scientific theory and qualitative research methods: Working in a research-related manner*]. Gyldendal. (In Norwegian).

Byrne, M. (2001). Hermeneutics as a methodology for textual analysis. *AORN Journal: The Official Voice of Perioperative Nursing*, *73*(5), 968–970.

Campbell, O. M. R., Cegolon, L., Macleod, D., & Benova, L. (2016). Length of Stay After Childbirth in 92 Countries and Associated Factors in 30 Low- and Middle-Income Countries: Compilation of Reported Data and a Cross-sectional Analysis from Nationally Representative Surveys. *PLOS Medicine*, *13*(3). https://doi.org/10.1371/journal.pmed.1001972

CASP. (2018). Critical Appraisal Skills Programme (CASP) Qualitative Checklist. Retrieved from: https://casp-uk.net/casp-tools-checklists/

Chin, R., Hall, P., & Daiches, A. (2011). Fathers' experiences of their transition to fatherhood: A metasynthesis. *Journal of Reproductive and Infant Psychology*, *29*(1), 4–18. https://doi.org/10.1080/02646838.2010.513044

Clancy, A. (2007). A profession under threat? An exploratory case study of changes in Norwegian public health nursing. *International Nursing Review*, *54*(2), 197–203. https://doi.org/10.1111/j.1466-7657.2007.00519.x

Cohrssen, C., Church, A., & Tayler, C. (2010). *Victorian Early Years Learning and Development Framework Evidence Paper. Practice Principle 1: Family-Centred Practice* [Report]. University of Melbourne, Melbourne Graduate School of Education. https://rune.une.edu.au/web/handle/1959.11/54431

Converse, M. (2012). Philosophy of phenomenology: How understanding aids research. *Nurse Researcher (through 2013)*, *20*(1), 28–32.

Correa, M. S., Feliciano, K. V., Pedrosa, E. N., & Souza, A. I. (2014). Women's Perception Concerning Health Care in the Post-Partum Period: A Meta-Synthesis. *Open Journal of Obstetrics and Gynecology*, *04*(07), 416–426. https://doi.org/10.4236/ojog.2014.47062

Coyne, I., Holmström, I., & Söderbäck, M. (2018). Centeredness in Healthcare: A Concept Synthesis of Family-centered Care, Person-centered Care and Child-centered Care. *Journal of Pediatric Nursing*, *42*, 45–56. https://doi.org/10.1016/j.pedn.2018.07.001

Crossman, A. (2020). The Major Theoretical Perspectives in Sociology. Retrieved from https://www.thoughtco.com/theoretical-perspectives-3026716

Dahl, B., Heinonen, K., & Bondas, T. E. (2020). From Midwife-Dominated to Midwifery-Led Antenatal Care: A Meta-Ethnography. *International Journal of Environmental Research and Public Health*, *17*(23), Article 23. https://doi.org/10.3390/ijerph17238946

Dahlberg, H., & Dahlberg, K. (2019). Open and Reflective Lifeworld Research: A Third Way. *Qualitative Inquiry*, 1077800419836696. https://doi.org/10.1177/1077800419836696

Dahlberg, H., & Dahlberg, K. (2020). Phenomenology of Science and the Art of Radical Questioning. *Qualitative Inquiry*, 1077800419897702. https://doi.org/10.1177/1077800419897702

Dahlberg, K. (2006). The essence of essences – the search for meaning structures in phenomenological analysis of lifeworld phenomena. *International Journal of Qualitative Studies on Health and Well-Being*, *1*(1), 11–19. https://doi.org/10.1080/17482620500478405

Dahlberg, K. (2019). The question of evidence in qualitative research. *Nordic Journal of Nursing Research*, *39*(1), 55–57. https://doi.org/10.1177/2057158518807855

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective lifeworld research* (2nd ed.). Studentlitteratur AB.

Dahlberg, K., & Segesten, K. (2010). *Hälsa och vårdande i teori och praxis* [*Health and care in theory and practice*]. (In Swidish). Natur och kultur.

Dahlberg, K., Todres, L., & Galvin, K. (2009). Lifeworld-led healthcare is more than patient-led care: An existential view of well-being. *Medicine, Health Care and Philosophy*, *12*(3), 265–271. https://doi.org/10.1007/s11019-008-9174-7

Dahlberg, U., Haugan, G., & Aune, I. (2016). Women's experiences of home visits by midwives in the early postnatal period. *Midwifery*, *39*, 57–62. https://doi.org/10.1016/j.midw.2016.05.003

Danbjørg, D. B., Wagner, L., & Clemensen, J. (2014). Do families after early postnatal discharge need new ways to communicate with the hospital? A feasibilility study. *Midwifery*, *30*(6), 725–732. https://doi.org/10.1016/j.midw.2013.06.006

Davies, L., & Hanna, E. (2021). The experience of qualitative research with young fathers: Considerations of gender, class and reflexive practice. *Families, Relationships and Societies*, *10*(3), 479–496. https://doi.org/10.1332/204674320X15919851992841

Delicate, A., Ayers, S., & McMullen, S. (2018). A systematic review and meta-synthesis of the impact of becoming parents on the couple relationship. *Midwifery*, *61*, 88–96. https://doi.org/10.1016/j.midw.2018.02.022

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, *8*(1), 54–63. https://doi.org/10.1177/160940690900800105

Eberhard-Gran, M. (2018). Nyfødte barn og sårbare mødre [Newborn children and vulnerable mothers]. *Tidsskrift for Den norske legeforening*. (In Norwegian) https://doi.org/10.4045/tidsskr.18.0878

Eberhard-Gran, M., Garthus-Niegel, S., Garthus-Niegel, K., & Eskild, A. (2010). Postnatal care: A cross-cultural and historical perspective. *Archives of Women's Mental Health*, *13*(6), 459–466. https://doi.org/10.1007/s00737-010-0175-1

Eddy, B., Poll, V., Whiting, J., & Clevesy, M. (2019). Forgotten Fathers: Postpartum Depression in Men. Journal of Family Issues, 40(8), 1001–1017. https://doi.org/10.1177/0192513X19833111

Edhborg, M., Carlberg, M., Simon, F., & Lindberg, L. (2016). "Waiting for Better Times": Experiences in the First Postpartum Year by Swedish Fathers with Depressive Symptoms. *American Journal of Men's Health*, *10*(5), 428–439. https://doi.org/10.1177/1557988315574740

Egeland, C., Pedersen, E., Nordberg, T., & Ballo, J. (2021). *Barnefamilienes hverdagsliv i Norge 2021* [The everyday life of families with children in Norway 2021]. Arbeidsforskningsinstituttet AFIs FoU-resultat 2021:06. (In Norwegian).

Ellberg, L., Högberg, U., & Lindh, V. (2008). 'We feel like one, they see us as two': New parents' discontent with postnatal care. *Midwifery*, *26*(4), 463–468. https://doi.org/10.1016/j.midw.2008.10.006

Engström, H. A., Borneskog, C., Häggström-Nordin, E., & Almqvist, A.-L. (2022). Professionals' experiences of supporting two-mother families in antenatal and child health care in Sweden. *Scandinavian Journal of Caring Sciences*, *37*(1), 250–259. https://doi.org/10.1111/scs.13111

Eriksson, K. (2002). Caring science in a new key. *Nursing science quarterly, 15(*1), 61-65.

Eriksson, K. (2018). *Vårdvetenskap: Vetenskapen om vårdandet. Om det tidlösa i tiden* [*Caring Science: The science of care. About the timeless in time*]. Liber. (In Swedish).

Finlay, L. (1998). Reflexivity: An Essential Component for All Research? *British Journal of Occupational Therapy*, *61*(10), 453–456. https://doi.org/10.1177/030802269806101005

Finlayson, K., Crossland, N., Bonet, M., & Downe, S. (2020). What matters to women in the postnatal period: A meta-synthesis of qualitative studies. PloS one, 15(4), e0231415. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0231415

Finlayson, K., Sacks, E., Brizuela, V., Crossland, N., Cordey, S., Ziegler, D., Langlois, E. V., Javadi, D., Comrie-Thomson, L., Downe, S., & Bonet, M. (2023). Factors that influence the uptake of postnatal care from the perspective of fathers, partners and other family members: A qualitative evidence synthesis. *BMJ Global Health*, *8* (Suppl 2), e011086. https://doi.org/10.1136/bmjgh-2022-011086

Forskningsrådet. (2022). *Porteføljeplan for helse. Brukerinvolvering og brukermedvirkning* [*Portfolio plan for health. User involvement and user participation*]. The Research Council of Norway. (In Norwegian). Retrieved from: https://www.forskningsradet.no/portefoljer/helse/portefoljeplanen-for-helse/prioriteringer/strukturelle-prioriteringer/

Forster, D. A., McLachlan, H. L., Rayner, J., Yelland, J., Gold, L., & Rayner, S. (2008). The early postnatal period: Exploring women's views, expectations and experiences of care using focus groups in Victoria, Australia. *BMC Pregnancy and Childbirth*, *8*, 27. https://doi.org/10.1186/1471-2393-8-27

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., Booth, A., Britten, N., Flemming, K., Gallagher, I., Garside, R., Hannes, K., Lewin, S., Noblit, G. W., Pope, C., Thomas, J., … Noyes, J. (2018). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *Journal of Advanced Nursing*, *0*(0). https://doi.org/10.1111/jan.13809

France, E. F., Ring, N., Thomas, R., Noyes, J., Maxwell, M., & Jepson, R. (2014). A methodological systematic review of what's wrong with meta-ethnography reporting. *BMC Medical Research Methodology*, *14*(1), 119. https://doi.org/10.1186/1471-2288-14-119

Gadamer, H. G. (2012/1960). *Sannhet og metode* [Truth and method]. Oslo: Pax forlag. (In Norwegian).

Garvan, J. (2016). At the crossroads: The health and welfare of new mothers. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, *52*(6), 753–770. https://doi.org/10.1080/10376178.2016.1248457

Gerrish, K., Lathlean, J., & Cormack, D. (2015). *The Research Process in Nursing.* 7th Edition. Wiley.

Giltenane, M., Sheridan, A., Kroll, T., & Frazer, K. (2021). Identifying the role of public health nurses during first postnatal visits: Experiences of mothers and public health nurses in Ireland. *International Journal of Nursing Studies Advances*, *3*, 100017. https://doi.org/10.1016/j.ijnsa.2020.100017

Giltenane, M., Sheridan, A., Kroll, T., & Frazer, K. (2022). Work environment challenging Irish public health nurses' care quality: First postnatal visit. *Public Health Nursing*, *39*(1), 202–213. British Nursing Index. https://doi.org/10.1111/phn.12993

Haga, S. M., Lynne, A., Slinning, K., & Kraft, P. (2012). A qualitative study of depressive symptoms and well-being among first-time mothers. *Scandinavian Journal of Caring Sciences*, *26*(3), 458–466. https://doi.org/10.1111/j.1471-6712.2011.00950.x

Hammarlund, K., Andersson, E., Tenenbaum, H., & Sundler, A. J. (2015). We are also interested in how fathers feel: A qualitative exploration of child health center nurses' recognition of postnatal depression in fathers. *BMC Pregnancy and Childbirth*, *15*(1), 290. https://doi.org/10.1186/s12884-015-0726-6

Helse- og omsorgstjenesteloven. (2011). Lov om kommunale helse- og omsorgstjenester [Health and Care Services Act]. (LOV-2011-06-24-30). Lovdata. (In Norwegian). Retrieved from: https://lovdata.no/dokument/NL/lov/2011-06-24-30

Helsetilsynet. (2014). Helsestasjonen – hjelp i rett tid? Oppsummering av landsomfattende tilsyn med helsestasjoner 2013 [The child health center - help at the right time? Summary of nationwide inspections of child health centers 2013]. *Rapport fra Helsetilsynet 4/2014*. (In Norwegian) https://www.helsetilsynet.no/globalassets/opplastinger/publikasjoner/rapporter2014/helsetilsynetrapport4_2014.pdf

Hilli, Y., & Eriksson, K. (2019). The home as ethos of caring: A concept determination. *Nursing Ethics*, *26*(2), 425–433. https://doi.org/10.1177/0969733017718395

Hjälmhult. (2019). *Helsestasjonstjenesten* [*The child health center service*]. (H. Holme, E. Olavsen, L. Valla, & M. Hansen, Eds.). Gyldendal Akademisk. (In Norwegian).

Hjälmhult, E., & Lomborg, K. (2012). Managing the first period at home with a newborn: A grounded theory study of mothers' experiences. *Scandinavian Journal of Caring Sciences*, *26*(4), 654–662. https://doi.org/10.1111/j.1471-6712.2012.00974.x

Hodgson, S., Painter, J., Kilby, L., & Hirst, J. (2021). The Experiences of First-Time Fathers in Perinatal Services: Present but Invisible. *Healthcare*, *9*(2), Article 2. https://doi.org/10.3390/healthcare9020161

Holm, K. G., Aagaard, H., Maastrup, R., Weis, J., Feenstra, M. M., Haslund-Thomsen, H., Hägi-Pedersen, M.-B., Nilsson, I., Kristensen, I. H., Dreier, S., Brødsgaard, A., & Visitor, H. (2022). How to support fathers of preterm infants in early parenthood – An integrative review. *Journal of Pediatric Nursing*, *67*, e38–e47. https://doi.org/10.1016/j.pedn.2022.10.001

Hrybanova, Y., Ekström, A., & Thorstensson, S. (2019). First-time fathers' experiences of professional support from child health nurses. *Scandinavian Journal of Caring Sciences*, *0*(0). https://doi.org/10.1111/scs.12690

Husserl, E. (1973/1939). *Experience and judgement* (J. S. Churchill & K. Ameriks, Trans). Evanston, IL, USA: NorthWestern University Press.

Husserl, E. (2001/1900). *Logical Investigations I-II* (J. N. Findlay, Trans). London: Routledge.

Johansson, K., Aarts, C., & Darj, E. (2010). First-time parents' experiences of home-based postnatal care in Sweden. *Upsala J ournal of Medical Sciences*, *115*(2), 131–137. https://doi.org/10.3109/03009730903431809

Johansson, M., Benderix, Y., & Svensson, I. (2020). Mothers’ and fathers’ lived experiences of postpartum depression and parental stress after childbirth: A qualitative study. *International Journal of Qualitative Studies on Health and Well-Being*, *15*(1), 1722564. https://doi.org/10.1080/17482631.2020.1722564

Johansson, M., & Thies-Lagergren, L. (2022). Women’s experience of the decision-making process for home-based postnatal midwifery care when discharged early from hospital: A Swedish interview study. *European Journal of Midwifery*, *6*(September), 1–7. https://doi.org/10.18332/ejm/152547

Johansson, M., Thies-Lagergren, L., & Wells, M. B. (2019). Mothers´ experiences in relation to a new Swedish postnatal home-based model of midwifery care–A cross-sectional study. *Midwifery*, *78*, 140–149. https://doi.org/10.1016/j.midw.2019.07.010

Jones, Stewart, Taylor, Davis, & Brown. (2021). Early postnatal discharge from hospital for healthy mothers and term infants. *Cochrane Database of Systematic Reviews*, *6*. https://doi.org/10.1002/14651858.CD002958.pub2

Kasen A, Nordman T, Lindholm T, & Eriksson K. (2008). «Då patienten lider av vården» – vårdares gestaltning av patientens vårdlidande [When the patient suffers from the care» – caregivers' portrayal of the patient's suffering from care]. (In Swedish) *Nordic Journal of Nursing Research & Clinical Studies / Vård i Norden*, *28*(2), 4–8. https://doi.org/10.1177/010740830802800202

Kokab, F., Jones, E., Goodwin, L., Taylor, B., & Kenyon, S. (2022). Community midwives’ views of postnatal care in the UK; A descriptive qualitative study. *Midwifery*, *104*, 103183. https://doi.org/10.1016/j.midw.2021.103183

Kowlessar, O., Fox, J. R., & Wittkowski, A. (2015). First-time fathers’ experiences of parenting during the first year. *Journal of Reproductive and Infant Psychology*, *33*(1), 4–14. https://doi.org/10.1080/02646838.2014.971404

Kronborg, H., Væth, M., & Kristensen, I. (2012). The Effect of Early Postpartum Home Visits by Health Visitors: A Natural Experiment. *Public Health Nursing*, *29*(4), 289–301. https://doi.org/10.1111/j.1525-1446.2012.01019.x

Kurth, E., Krähenbühl, K., Eicher, M., Rodmann, S., Fölmli, L., Conzelmann, C., & Zemp, E. (2016). Safe start at home: What parents of newborns need after early discharge from hospital - a focus group study. *BMC Health Services Research*, *16*, 1–14. https://doi.org/10.1186/s12913-016-1300-2

Kvale, S., & Brinkmann, S. (2017). *Det kvalitative forskningsintervju* [*The qualitative research interview*]. (In Norwegian) (3rd ed.). Gyldendal Akademisk.

Langlois, É. V., Miszkurka, M., Zunzunegui, M. V., Ghaffar, A., Ziegler, D., & Karp, I. (2015). Inequities in postnatal care in low- and middle-income countries: A systematic review and meta-analysis. *Bulletin of the World Health Organization*, *93*, 259-270G. https://doi.org/10.2471/0042-9686-bwho-93-04-259

Lassemo, E., & Melby, L. (2020). Helsesykepleiere i helsestasjons- og skolehelsetjenesten. *Status, utvikling og behov* [*Public health nurses in the child-well-clinics and school health services*]. (In Norwegian). 1346.

Leahy-Warren, P., Philpott, L., Elmir, R., & Schmied, V. (2022). Fathers' perceptions and experiences of support to be a parenting partner during the perinatal period: A scoping review. *Journal of Clinical Nursing*, *n/a*(n/a). https://doi.org/10.1111/jocn.16460

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. sage.

Lindberg, I., Öhrling, K., & Christensson, K. (2008). Expectations of post-partum care among pregnant women living in the north of Sweden. *International Journal of Circumpolar Health*, *67*(5), 472–483. https://doi.org/10.3402/ijch.v67i5.18354

Lindblad, V., Gaardsted, P. S., & Melgaard, D. (2021). Early discharge of first-time parents and their newborn: A scoping review. *European Journal of Midwifery*, *5*, 46. https://doi.org/10.18332/ejm/140792

Lor, M., Crooks, N., & Tluczek, A. (2016). A proposed model of person-, family-, and culture-centered nursing care. *Nursing Outlook*, *64*(4), 352–366. https://doi.org/10.1016/j.outlook.2016.02.006

Malterud, K. (2017). *Kvalitative forskningsmetoder for medisin og helsefag [Qualitative research methods for medicine and health professions]*. Universitetsforlaget. (In Norwegian).

Martinsen, K. (2006). *Care and vulnerability*. Akribe.

Mehrara, L. (2020). Seeking the Ideal of Universalism within Norway's Social Reality. *Social Inclusion*, *8*(1), 133–144.

Meld. St.12 (2008-2009). *En gledelig begivenhet — Om en sammenhengende svangerskaps-, fødsels- og barselomsorg* [*A joyful event — About a coherent pregnancy, birth and maternity care*]. Helse- og omsorgsdepartementet. (In Norwegian). https://www.regjeringen.no/no/dokumenter/stmeld-nr-12-2008-2009-/id545600/

Meleis, A. (2010). *Transitions Theory: Middle Range and Situation Specific Theories in Nursing Research and Practice*. Springer Publishing Company.

Merleau-Ponty, M. (2005/1945). *Phenomenology of Perception.* (C. smith, Trans.). London: Routledge and Kegan Paul.

Monteiro, L. A. (1985). Florence Nightingale on public health nursing. *American Journal of Public Health*. https://doi.org/10.2105/AJPH.75.2.181

Nilsson, I., Danbjørg, D. B., Aagaard, H., Strandberg-Larsen, K., Clemensen, J., & Kronborg, H. (2015). Parental experiences of early postnatal discharge: A meta-synthesis. *Midwifery*, *31*(10), 926–934. https://doi.org/10.1016/j.midw.2015.07.004

Nilsson, I. M. S., Kronborg, H., Knight, C. H., & Strandberg-Larsen, K. (2017). Early discharge following birth – What characterises mothers and newborns? *Sexual & Reproductive Healthcare*, *11*, 60–68. https://doi.org/10.1016/j.srhc.2016.10.007

Noblit, G. W., & Hare, R. D. (1988). *Meta-Ethnography*. SAGE Publications, Inc.

Noonan, M., Galvin, R., Doody, O., & Jomeen, J. (2017). A qualitative meta-synthesis: Public health nurses role in the identification and management of perinatal mental health problems. *Journal of Advanced Nursing*, *73*(3), 545–557. https://doi.org/10.1111/jan.13155

Norlyk, A., Haahr, A., & Hall, E. (2016). Interviewing with or without the partner present? – An underexposed dilemma between ethics and methodology in nursing research. *Journal of Advanced Nursing*, *72*(4), 936–945. https://doi.org/10.1111/jan.12871

NSF, Landsgruppen av helsesøstre. (2011). Spesialistgodkjenning av helsesøstre [Specialist approval of public health nurses]. (In Norwegian).

Nyström, L., Lindström, U. Å., Zetterlund, J. E., & Alligood, M. R. (2022). *Katie Eriksson: Theory of Caritative Caring in Nursing theorists and their work* (M. R. Alligood, Ed.). Elsevier.

Online Etymology Dictionary. (2023). *Nursing. Retrieved from: https://www.etymonline.com/*

Online Etymology Dictionary. (2023). *Caring*. Retrieved from: https://www.etymonline.com/

Persson EK, Fridlund B, Kvist LJ, & Dykes A. (2010). Mothers' sense of security in the first postnatal week: Interview study. *Journal of Advanced Nursing*, *67*(1), 105–116. https://doi.org/10.1111/j.1365-2648.2010.05485.x

Polit, D. F., & Beck, C. T. (2021). *Nursing research-Generating and Assessing Evidence for Nursing Research (11 uppl.)*. Wolters Kluwer.

Rautio, S. (2013). Parents' experiences of early support. *Scandinavian Journal of Caring Sciences*, *27*(4), 927–934. https://doi.org/10.1111/scs.12006

Richards, L., & Morse, J. M. (2012). *Readme first for a user's Guide to Qualitative Methods*. Sage.

Ridgway, L., Hackworth, N., Nicholson, J. M., & McKenna, L. (2021). Working with families: A systematic scoping review of family-centred care in universal, community-based maternal, child, and family health services. *Journal of Child Health Care*, *25*(2), 268–289. https://doi.org/10.1177/1367493520930172

Rydström, L.-L., Tavallali, A., Sundborg, E., Berlin, A., & Ranheim, A. (2021). Caught on the Fringes of Life: Mothers' Lived Experiences of Initial Breastfeeding Complications. *Qualitative Health Research*, *31*(9), 1622–1631. https://doi.org/10.1177/10497323211002484

Sacks, E., Finlayson, K., Brizuela, V., Crossland, N., Ziegler, D., Sauvé, C., Langlois, É. V., Javadi, D., Downe, S., & Bonet, M. (2022). Factors that influence uptake of routine postnatal care: Findings on women's perspectives from a qualitative evidence synthesis. *PloS One*, *17*(8), e0270264. https://doi.org/10.1371/journal.pone.0270264

Sandelowski, M., & Barroso, J. (2007). *Handbook for Synthesizing Qualitative Research*. Springer Publishing Company.

Sandelowski, M., Barroso, J., & Voils, C. I. (2007). Using qualitative metasummary to synthesize qualitative and quantitative descriptive findings. *Research in Nursing & Health*, *30*(1), 99–111. https://doi.org/10.1002/nur.20176

Schiøtz, A. (2003). *Det offentlige helsevesen i Norge 1603-2003. Folkets helse—Landets styrke* [*The public health system in Norway 1603-2003. The people's health—The country's strength*]. (In Norwegian). Universitetsforlaget.

Shaw, E., Levitt, C., Wong, S., Kaczorowski, J., & Group, T. M. U. P. R. (2006). Systematic Review of the Literature on Postpartum Care: Effectiveness of Postpartum Support to Improve Maternal Parenting, Mental Health, Quality of Life, and Physical Health. *Birth*, *33*(3), 210–220. https://doi.org/10.1111/j.1523-536X.2006.00106.x

Shields, L., Pratt, J., & Hunter, J. (2006). Family centred care: A review of qualitative studies. *Journal of Clinical Nursing*, *15*(10), 1317–1323. https://doi.org/10.1111/j.1365-2702.2006.01433.x

Shorey, S., & Ang, L. (2019). Experiences, needs, and perceptions of paternal involvement during the first year after their infants' birth: A meta-synthesis. *PLOS ONE*, *14*(1), e0210388. https://doi.org/10.1371/journal.pone.0210388

Shorey, S., Dennis, C.-L., Bridge, S., Chong, Y. S., Holroyd, E., & He, H.-G. (2017). First-time fathers' postnatal experiences and support needs: A descriptive qualitative study. *Journal of Advanced Nursing*, *73*(12), 2987–2996. https://doi.org/10.1111/jan.13349

Sievertsen, H. H., & Wüst, M. (2017). Discharge on the day of birth, parental response and health and schooling outcomes. *Journal of Health Economics*, *55*, 121–138. https://doi.org/10.1016/j.jhealeco.2017.06.012

Slomian, J., Emonts, P., Vigneron, L., Acconcia, A., Glowacz, F., Reginster, J. Y., Oumourgh, M., & Bruyère, O. (2017). Identifying maternal needs following childbirth: A qualitative study among mothers, fathers and professionals. *BMC Pregnancy and Childbirth*, *17*(1). https://doi.org/10.1186/s12884-017-1398-1

Solberg, B., Glavin, K., Berg, R. C., & Olsvold, N. (2022). "Opening up a well of emotions": A qualitative study of men's emotional experiences in the transition to fatherhood. *Nursing Open*. https://doi.org/10.1002/nop2.1482

Steen, M., Downe, S., Bamford, N., & Edozien, L. (2012). Not-patient and not-visitor: A metasynthesis fathers' encounters with pregnancy, birth and maternity care. *Midwifery*, *28*(4), 422–431. https://doi.org/10.1016/j.midw.2011.06.009

SSB. (2023). *Befolkning, fødte og døde* [*Population, births and deaths*]. Oppdatert 07.03.2023. Statistisk sentralbyrå. (In Norwegian). Retrieved from: https://www.ssb.no/befolkning/fodte-og-dode/statistikk/fodte

Suddick, K. M., Cross, V., Vuoskoski, P., Galvin, K. T., & Stew, G. (2020). The Work of Hermeneutic Phenomenology. *International Journal of Qualitative Methods*, *19*, 1609406920947600. https://doi.org/10.1177/1609406920947600

Taylor, B., & de Vocht, H. (2011). Interviewing Separately or as Couples? Considerations of Authenticity of Method. *Qualitative Health Research*, *21*(11), 1576–1587. https://doi.org/10.1177/1049732311415288

The Norwegian Directorate of Health. (2014). *Nytt liv og trygg barseltid for familien. Nasjonal faglig retningslinje for barselomsorgen* [*New life and a safe maternity period for the family. National professional guideline for maternity care*]. (In Norwegian). Retrieved from: https://www.helsedirektoratet.no/retningslinjer/barselomsorgen

The Norwegian Directorate of Health. (2022). Nasjonal faglig retningslinje for helsestasjon, skolehelsetjeneste og helsestasjon for ungdom [National professional guidelines for child health centres, school health services and health centers for young people]. (In Norwegian). Retrieved from: https://www.helsedirektoratet.no/retningslinjer/helsestasjons-og-skolehelsetjenesten

Thies-Lagergren, L., & Johansson, M. (2023). Home-based postnatal midwifery care facilitated a smooth succession into motherhood: A Swedish interview study. *European Journal of Midwifery*, *7*(April), 1–8. https://doi.org/10.18332/ejm/161784

Thomas, J. E., Bonér, A.-K., & Hildingsson, I. (2011). Fathering in the first few months. *Scandinavian Journal of Caring Sciences*, *25*(3), 499–509. https://doi.org/10.1111/j.14716712.2010.00856.x

Tveit, G. N. I., & Söderhamn, U. S. U. (2015). Hva gjør førstegangsmødre for å mestre barnestellet i tidlig barseltid? [What do first-time mothers do to master childcare in early maternity?] (In Norwegian). *Nordisk sygeplejeforskning*, *5*(02), 151–164.

Valla, L., Helseth, S., Småstuen, M. C., Misvær, N., & Andenæs, R. (2022). Factors associated with maternal overall quality of life six months postpartum: A cross sectional study from The Norwegian Mother, Father and Child Cohort Study. *BMC Pregnancy and Childbirth*, *22*(1), 4. https://doi.org/10.1186/s12884-021-04303-5

Walker, S. B., Rossi, D. M., & Sander, T. M. (2019). Women’s successful transition to motherhood during the early postnatal period: A qualitative systematic review of postnatal and midwifery home care literature. *Midwifery*, *79*, 102552. https://doi.org/10.1016/j.midw.2019.102552

Wells, M. B. (2016). Literature review shows that fathers are still not receiving the support they want and need from Swedish child health professionals. *Acta Paediatrica*, *105*(9), 1014–1023. https://doi.org/10.1111/apa.13501

Wells, M. B., & Lang, S. N. (2016). Supporting same-sex mothers in the Nordic child health field: A systematic literature review and meta-synthesis of the most gender equal countries. *Journal of Clinical Nursing*, *25*(23–24), 3469–3483. https://doi.org/10.1111/jocn.13340

Werner-Bierwisch, T., Pinkert, C., Niessen, K., Metzing, S., & Hellmers, C. (2018). Mothers' and fathers' sense of security in the context of pregnancy, childbirth and the postnatal period: An integrative literature review. *BMC Pregnancy & Childbirth*, *18*(1), N.PAG-N.PAG. c8h. https://doi.org/10.1186/s12884-018-2096-3

Whitehead, L. (2004). Enhancing the quality of hermeneutic research: Decision trail. *Journal of Advanced Nursing*, *45*(5), 512–518. https://doi.org/10.1046/j.1365-2648.2003.02934.x

World Health Organization. (2015). *WHO recommendations on health promotion interventions for maternal and newborn health 2015*. WHO. Retrieved 24 May 2023, from https://www.who.int/publications-detail-redirect/9789241508742

World Health Organization. (2022). *WHO recommendations on maternal and newborn care for a positive postnatal experience*. WHO. Retrieved 18 November 2022, from https://www.who.int/publications-detail-redirect/9789240045989

World Health Organization. (2010). *WHO Technical Consultation on Postpartum and Postnatal Care*. WHO. http://www.ncbi.nlm.nih.gov/books/NBK310591/

World Medical Association. (2013). World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. Jama, 310(20), 2191-2194.

Wiklund Gustin, L., & Wagner, L. (2013). The butterfly effect of caring – clinical nursing teachers' understanding of self-compassion as a source to compassionate care. *Scandinavian Journal of Caring Sciences*, *27*(1), 175–183. https://doi.org/10.1111/j.1471-6712.2012.01033.x

Wiklund, I., Wiklund, J., Pettersson, V., & Boström, A.-M. (2018). New parents' experience of information and sense of security related to postnatal care: A systematic review. *Sexual & Reproductive Healthcare*, *17*, 35–42. https://doi.org/10.1016/j.srhc.2018.06.001

Yonemoto, N., Dowswell, T., Nagai, S., & Mori, R. (2014). Schedules for home visits in the early postpartum period. *Evidence-Based Child Health*, *9*(1), 5–99. https://doi.org/10.1002/ebch.1960

Yonemoto, N., Nagai, S., & Mori, R. (2021). Schedules for home visits in the early postpartum period. *Cochrane Database of Systematic Reviews*, *2021*(7). https://doi.org/10.1002/14651858.cd009326.pub4

Zadoroznyj, M., Brodribb, W. E., Young, K., Kruske, S., & Miller, Y. D. (2015). 'I really needed help': What mothers say about their post-birth care in Queensland, Australia. *Women and Birth*, *28*(3), 246–251. https://doi.org/10.1016/j.wombi.2015.03.004

Zahavi, D. (2018). *Fænomenologi: En introduktion* [*Phenomenology: An Introduction*] (In Danish). København: Samfundslitteratur.

Part II

Papers

Paper I

INTERNATIONAL JOURNAL OF QUALITATIVE STUDIES ON HEALTH AND WELL-BEING
2021, VOL. 16, 1918887
https://doi.org/10.1080/17482631.2021.1918887

Taylor & Francis
Taylor & Francis Group

EMPIRICAL STUDIES

OPEN ACCESS Check for updates

Going blindly into the women's world: a reflective lifeworld research study of fathers' expectations of and experiences with municipal postnatal healthcare services

Bente Kristin Høgmo, Terese Bondas and Marit Alstveit

Department of Public Health, Faculty of Health Sciences, University of Stavanger, Stavanger, Norway

ABSTRACT

Purpose: The aim of this study is to describe new fathers' expectations of and experiences with municipal postnatal healthcare services.

Methods: A phenomenological reflective lifeworld research (RLR) approach has been used. Ten fathers were interviewed about their expectations of and experiences with municipal postnatal healthcare services, and the data were analysed to elucidate a meaning structure for the phenomenon.

Results: The essential meaning of the phenomenon of fathers' expectations of and experiences with municipal postnatal health care described as *going blindly into the women's world.* The essential meaning is further explicated through its four constituents: not knowing what to ask for, feeling excluded, seeking safety for the family and longing for care.

Conclusions: Entering the postnatal period with sparse knowledge about the child and family healthcare services available is difficult for the fathers who do not know what to ask for and what to expect. The fathers' feel excluded by the public health nurse, and the postnatal health care is seen as a mother–baby–public health nurse triad. The feeling of exclusion and inequality might be avoided if public health nurses focused both on mothers' and fathers' individual follow-up needs in the postnatal period and on seeing the newborn baby and the parents as a family unit.

ARTICLE HISTORY
Accepted 14 April 2021

KEYWORDS
Child and family healthcare services; expectations; experiences; fathers; reflective lifeworld research; postnatal health care; public health nurse

Introduction

Most high-income countries offer postnatal healthcare services for the families, both at the hospital of birth and in the municipalities where the families live. Early discharge from hospital for mother and child after birth (6–72 hours) is a growing trend in several countries, and this has been claimed to be a more family-centred approach in postnatal health care (Brown et al., 2009). Early discharge is found to encourage the mothers and fathers to take responsibility which contributes towards bolstering their confidence in their parental role (Nilsson et al., 2015). Many fathers can play a vital role as a parent and support person for the mother. However, the father's role as an equal parent and caregiver may not be well enough acknowledged in cases of maternity care where the father often is named partner instead of parent (Duvander et al., 2010; Steen et al., 2012). Studies report that many fathers want to be involved in the child's life from the very beginning (Plantin et al., 2011; Wells, 2016). Early involvement in giving care after the birth has a positive influence not only on the fathers themselves but also on their partners and on the child's psychological, behavioural and social development and well-being (Plantin et al., 2011; Wells, 2016). The ability of the parents to share in caregiving and taking part in postnatal care might be facilitated by the availability of parental leave; in the Nordic countries, most employers offer parental leave for fathers (Sederström, 2019). Nevertheless, fewer than half of the world's countries offer paid paternity leave on the birth of a child, and often this amounts to less than three weeks (Van der Gaag et al., 2019).

Meanwhile, studies show that expectant and new fathers often lack relevant information, guidelines and role models to support them in their transition to the fathering role and parenthood (Chin, Daiches et al., 2011; Deave & Johnson, 2008). Some fathers find their new role demanding, and new fathers' need guidance in obtaining relevant information to prepare for the early postnatal period (Åsenhed et al., 2014; Pålsson et al., 2017). Thus, support in establishing realistic expectations of fatherhood has been highlighted as an important task for health professionals in the meeting with new fathers. Fathers want to have a relationship of trust with the public health nurse (PHN) offering postnatal health care in the

CONTACT Bente Kristin Høgmo bente.k.hogmo@uis.no Department of Public Health, Faculty of Health Sciences, University of Stavanger, Stavanger, Norway

municipal; they want to feel welcome and receive answers to their questions (Fägerskiöld, 2006; Wells, 2016). A father who perceives that health professionals see him only as an assistant and practical helper instead of a parent equal to the mother will feel insecure and incapable of supporting his partner (Feenstra et al., 2018; Steen et al., 2012). In a family-centred care (FCC) perspective, the partnership between the family and the healthcare provider is paramount, and studies have corroborated that this approach has improved the quality of care and resulted in increased trust and satisfaction (Coyne et al., 2018). Nevertheless, some fathers prefer support from persons other than health professionals; fathers who can talk to male workmates and friends about infant care have less need for a trustful relationship with the PHN (Fägerskiöld, 2006). Even with increased attention on the family and the paternal involvement, Hrybanova et al. (2019) report that fathers want healthcare services to treat fathers as caregivers in the consultations with the family. Becoming a father has been described by first-time fathers as an emotional roller coaster (Åsenhed et al., 2014). Communicating and sharing experiences and expectations through blogs on the internet, expectant fathers expressed that the transition to fatherhood was complex and involved both positive expectations for the future and feelings of frustration. Although some men experience psychological distress during the perinatal period, they might question the legitimacy of their experiences and feel reluctant or struggle to express their needs for support (Darwin et al., 2017). A systematic review on new parents found that depressed fathers report an imbalance between their need for support and the support they got from their partner and significant others, and it seemed like fathers had more difficulties asking for help than mothers (Holopainen & Hakulinen, 2019). Paternal depression and anxiety during the perinatal period is not just a problem for the fathers and their families; it is also a significant public health concern (Darwin et al., 2017). The literature search for qualitative studies on parents' expectations of and experiences with postnatal health care seem almost solely to focus on mothers, and we found scarcely any studies on municipal postnatal health care for fathers (Barimani et al., 2015; Fägerskiöld & Ek, 2003; Huusko et al., 2018). This indicates a gap in the knowledge of the phenomenon of fathers' expectations of and experiences with municipal postnatal healthcare services.

Aim

The aim of this study was to describe new fathers' expectations of and experiences with municipal postnatal healthcare services.

Method

A phenomenological reflective lifeworld research (RLR) approach was chosen because RLR aims at describing the lived world in a way that increases our understanding of human beings and human experience (Dahlberg et al., 2008). The lived experiences are related to being a part of the world and human existence, characterized by an unreflected and taken-for-granted way of living and experiencing the world (Dahlberg et al., 2008). To let the phenomenon "show itself", a sensitive openness focusing on a deliberate exclusion of assumptions and expectations is necessary (Dahlberg et al., 2008). In RLR, the researcher's openness in the search for meaning is made visible through an attitude called "bridling" (Dahlberg & Dahlberg, 2019; Dahlberg et al., 2008). According to Dahlberg et al. (2008) bridling means having an open and alert attitude throughout the research process in order to slow down the process of understanding and going beyond our natural attitude. The researchers performing this study have clinical experience as PHNs in CFHC, and they are all mothers. Having this insider perspective, it was especially important to recognize, reflect upon and bridle our pre-understanding. By using the methodological principles referred to in RLR as openness, flexibility and bridling in the search for the phenomenon of new fathers' expectations of and experiences with the postnatal health care, the phenomenon is explored in a scientific way focusing on not making definite what is still indefinite (Dahlberg et al., 2008).

Setting and participants

This study is part of a larger research project that investigated new parents' expectations of and experiences with municipal postnatal healthcare services. In Norway, municipal postnatal health care is provided for the family at CFHCs; the services are free of charge and low-threshold, following a standardized programme with regular consultations, including a home visit for newborns seven to ten days after birth. The goal of the Norwegian municipal postnatal health care is to support the parents, facilitate the parent-child attachment and mastery of the parental role. Breastfeeding and parental mental health are also important topics to be addressed by PHNs in the postnatal period (The Norwegian Directorate of Health, 2014). PHNs employed at municipal CFHCs are the primary care providers for the child and family from postnatal hospital discharge and up until the child is five years old. In addition, an early home visit by a midwife is recommended (Norwegian Directorate of Health, 2019). In Norway, more than 99% of the PHNs and midwives are women (Statistics Norway, 2019), like in Europe around 85% of all nurses are women (Boniol et al., 2019).

To gain insight and in-dept understanding of the phenomenon a purposive sampling strategy was used (Patton, 2014). Ten couples (ten mothers and fathers) participated in the study and were recruited with the help of midwives from the maternity hotel at one hospital and midwives at a CFHC in one county in the south-western region of Norway. Two couples were recruited by snowball sampling. Inclusion criteria were couples who had recently become parents, parents of different sexes, mastering Scandinavian language, mother and infant discharged from hospital within the third day after birth without the need for additional follow-up and the parents planned to utilize CFHC. One of the couples came from another Nordic country, the rest came from Norway. Six of the men were first-time fathers and four fathers were having their second child, and each father was living with the mother of the child. They were from 24 to 33 years old with a mean age of 28. The fathers' educational level was high school (7) and university degree (3), and they were all employed and came from both urban and rural areas.

Data collection

In order to turn to the new fathers' lifeworld, interviews were used to explore the phenomenon of fathers' expectations of and experiences with municipal postnatal health care. To serve the purpose of establishing an open and reflective dialogue, the interview was carried out with a focus on striking a balance between the structured and unstructured (Dahlberg et al., 2008). To direct the interviewee's intentionality, their feelings and thoughts towards the phenomenon, the fathers were asked "can you please describe how you have experienced the first days at home with a new baby", "what expectations do you have to the postnatal health care?" and "what experiences do you have in relation to the follow-up you and your family have received from the CFH services in the postnatal period?". To gain a deeper understanding, follow-up questions were asked such as "can you please tell me more?" and "what has been important to you?".

Data were collected twice, and in the first interviews, the fathers were interviewed together with the mother shortly after returning home from hospital. In the second interview, when the postnatal period was over (6 to 8 weeks after birth), the fathers were interviewed separately. In the joint interviews, the questions were directed at mother or father, and some questions were for common reflection. The two approaches complement each other in elucidating different aspects of the fathers' expectations and experiences (Taylor & De Vocht, 2011) and conducting interviews with both the mother and father as a couple and afterwards individually provides an opportunity to both deepen and broaden the content of the data collected (Norlyk et al., 2016). When studying a phenomenon like shared experiences, joint interviews are helpful in elucidating what is often tacit knowledge (Polak & Green, 2016). In the present study the parents' shared reflections assisted to bring new aspects into the conversation about their expectations and experiences. Another reason for conducting two interviews was to obtain expectations and experiences during the postnatal period and provide room for reflection for the fathers between the interviews. It also gave the interviewer an opportunity to follow up topics that had been discussed in the couple interview. In the joint interviews, the infant was present in the room during the interview, which to some extent affected the parents' attention and presence. All the fathers chose their own homes as setting for the interviews.

The data collection was conducted from October 2019 to March 2020. The interviews were conducted by the first author, audio recorded and transcribed verbatim and lasted between 10 and 60 minutes (mean 35 min).

Analysis

The interviews were transcribed verbatim and analysed according to the RLR approach described by Dahlberg et al. (2008). We strove to pursue the methodological principles of openness and flexibility, and we took a bridled attitude during the analysis process. The analysis of the data was characterized by a flexible movement between the whole and the parts, towards a new whole to describe the essential meaning structure of the phenomenon and its variations of meaning, called the constituents. The first step in the analysis process was reading and re-reading the interview transcripts to create an understanding of the whole text. This understanding served as a background on which the various parts in the individual descriptions could be understood. Moreover, through openness, the data were read with curiosity as we sought for the "otherness", something new. Furthermore, the findings were discussed and reflected on by all authors in the search for meanings and variations of meanings, and in a dialogue including questions asked such as, "What is being said in the text?", "How is it said?" and "What is the meaning?". To increase the openness and reflection in the process of understanding the phenomenon, we repeatedly asked the question of whether the text could be understood in another way. Next, meaning units where identified and clustered together based on similarities and differences, forming a temporary pattern of meanings. Finally, the clustered meanings were re-read and the essential meaning of the phenomenon on an abstract level emerged. After clarifying the essence, the constituents were further described on a more concrete level and quotations from both the joint and the individual interviews were used to further illustrate the constituents. In the analyses of the data from the joint interviews, we used a non-dyadic approach and treated the data as coming from two separate individuals. The parents shared the same experience of having a baby and receiving postnatal health care in the municipality, but they may relate to those experiences differently and have different expectations regarding the encounter with the PHN and CFHC. Quotations from fathers in the joint (J) and individual (I) interviews were number coded and presented under each constituent.

Ethical considerations

This study was designed and conducted in accordance with the principles in the Helsinki Declaration (World Medical Association Declaration of Helsinki, 2013) and was approved by the regional committee for medical and health research ethics (REC) (reg. no: 2019/7220) and by the Norwegian Centre for Research Data (NSD) (project number: 420055).)A data management plan was prepared for the project according to NSD's template (Norwegian Centre for Research Data, 2021). All interviews were coded to guarantee participant confidentiality and the parents received both verbal and written information about the aim of the study, anonymity and the confidentiality of any data given. They were also told that they had the right to withdraw from the study at any time. The participants gave their written informed consent prior to the interviews.

Results

The essential meaning of fathers' expectations of and experiences with municipal postnatal health care can be described as going blindly into the women's world. The new fathers' enter the postnatal period with a lack of information about what postnatal care in the municipality can offer to the new family. Not knowing what to expect from the PHN and the CFHC is described as "going blindly", and this makes it difficult to have any expectations in advance. Parenthood is seen as a joint project where both parents are important in caring for the newborn child. This stands in contrast to the manner in which the fathers perceive being met by PHN and CFHC. A feeling of being left out and excluded is predominant and adds to an image of a world *of* and *for* women which causes uncertainty about the extent to which postnatal care is a service offered to fathers as well as mothers. In the initial phase at home, fathers strive to safeguard the baby and the family, and in that context, the comfort of security is essential and serves as a necessary foundation when building a framework around the new family. An inclusive and accessible CFHC service is needed to guarantee a feeling of security. Early home visits by PHN are positive and good experiences which greatly contribute to safety. Receiving visits from competent professionals on the family's own terms in a vulnerable transition phase is deemed a major strength. Feeling included, equal and safe is closely linked to care and while striving for the safety of their family, fathers appreciate the recognition and caring supervision of the PHN. A desire to be acknowledged and taken care of is expressed, and this underscores that fathers also need care during the postpartum period.

The essential meaning is further elaborated in the following four constituents: Not knowing what to ask for, Feeling excluded, Seeking safety for the family, and Longing for care.

Not knowing what to ask for

The transition between hospital and home was experienced as a vulnerable phase for both the first-time and second-time fathers. The period of the first days and weeks at home with the newborn baby was described as filled with joy and gratitude, but it was also experienced as a phase entailing many questions and concerns. The fathers expressed having received little or no advance information about the CFHC offers in the postnatal period. Not knowing what the postnatal health care contained and represented for the family was experienced as going blindly and thus made it difficult for the fathers to describe their expectations. In the joint interview, one first-time father reflected upon his expectations and stated: "I don't know exactly what to expect because I have never encountered this before. Everything is completely new" (JF5). When returning to the topic in the individual interview, the same father stated that not knowing what was going to happen when the parents came to the CFHC for the first time led to a stressful encounter with the service: "You are a bit blind when you go in there (CFHC), in relation to what is going to happen and how they do things" (IF5).

Another father expressed that he was disappointed about not having received written information about the service: "I had no expectations. I was expecting follow-up, and I got it, but—well, it was not so much in my mind. It would have been nice to get a small brochure or leaflet about the CFHC offer, in addition to the website" (JF3).

Some of the fathers' reflections on the lack of expectations were that they needed a better knowledge base about the postnatal care and what the CFHC could offer, and wished they had this information at an earlier stage. They also described a desire to learn from other fathers' experiences of having a baby and being able to discuss issues related to fatherhood. Sparse information about the CFHC, combined with the impression that the service's target group was primarily the mother and the child made some of the fathers unsure as to whether or not this was an offer for fathers as well: "There is a lot that pertains to the mother and child. I'm not sure I feel that the CFHC service is an offer for me" (JF5).

Getting time off from work to accompany the mother and child to the CFHC was described as difficult by most of the fathers. Some stated that it was important that PHN planned and arranged for the father to be able to have access to the CFHC. Several fathers wanted more flexible opening hours and offers that were adapted to the fathers' interests and needs:

> I think that courses such as COS (Circle of Security), are very important to arrange so that both parents can go. It would also be nice to have a check-up dedicated to the parent who didn't normally go to the CFHC; that would have been cool … I do not think they have it, but it would have been a nice thing really. (IF6)

The fathers said that they would have liked to get more information, knowledge and guidance related to the baby's growth, health, and well-being. This knowledge was closely linked to the feeling of security when they were alone with the baby, feeling included by the PHN and feeling equal as a caregiver: "I regretted not getting more knowledge about children's health … to learn the highest fever that is okay and so on … when the mother is not there. I as father would have liked to know a little more about everything related to the child's health during the first year" (JF4).

Feeling excluded

The fathers' experiences with the CFHC seemed to vary depending on the contact and support from the PHN during the postnatal period. The fathers said that today's fathers are different from the generations before them and noted that today, new fathers perceive parenting as teamwork. They want to be active and present in the child's life from the very beginning. They believe that the father is important to both the child and the mother in the postnatal period. At the same time, the fathers said that they experienced that all information and communication with PHN and CFHC went through the mother. This was described as a feeling of being left out and excluded: "I could have been more included, if they had sent me a copy of the e-mails, or if I received a letter or … because as it is now, the mother gets everything" (IF1).

The fathers regarded parenting as teamwork and having children was described as something you do together. Not being able to take part in the consultations at the CFHC was described as though the mother had a monopoly on the child's health and development:

> It is important for the CFHC to be aware that it easily can be the mother who gets a monopoly over the child's development and well-being in the beginning. Breastfeeding is one thing, but it is these other things like what position one should put the baby down, general training for the baby and all these other things, it would have been nice if both were involved in this. I believe many fathers, including myself, think it's nice to be involved. But you have to be given permission to get involved … given that mandate in a way. I think that the health professionals at the CFHC certainly can think through how things are carried out based on the fact that one should include the father too. (IF6)

One of the fathers had experienced that the PHN planned the home visit when the maternity leave was over, and he had to go back to work. Not being able to be there when the PHN came on a home visit made the father feel shut out and insignificant in relation to the mother and baby: "I have not spoken with her (the PHN). The home visit was the same day I started working again … they know the dates when we are going back to work—they could have planned a little better" (IF1).

One of the second-time fathers was not aware that he could accompany mother and child to the consultations at the CFHC and regretted not being informed and invited by PHN: "No, I don't think it was expected that I should come—I don't think so. She (PHN) should have invited me or said something at the home visit, that the father is welcome to join. Because he is, isn't he?" (IF8).

Several fathers had experienced that the PHN did not expect the father to attend the consultations at the CFHC. They felt that it was not a "must" that they participated, but that they could join if they wanted. This might have led to a feeling of not being significant as a caregiver and gave the impression that the follow-up was for mother and child: "If it is expected that both will join, then we will join. If it is not expected, then it ends up with only the mother going—that's how it is, that's the reality of the situation" (IF4).

One of the second-time fathers described how he had experienced attending a group offer at the CFHC in the postnatal period with his first child: "Based on my experiences with postnatal group meetings at CFHC from the last time, there was very little directed at father. Nothing was aimed for dad—it was a waste of two hours" (JF7). Several fathers expressed that they wanted their own arena where they could meet other fathers, share experiences and talk about topics related to infancy and early childhood that concern them. A group offer for new fathers was described as a CFHC offer they would have attended if there was one. Such an offer was also seen as an arena for building relationships and preventing loneliness during paternity leave:

> If the CFHC had one day a week with longer opening hours … I don't think they have, but it would have been a really nice thing, and maybe set up a meeting or something for fathers and children … yes, encourage it, because then maybe more fathers would dare, maybe not everyone thinks that they should, that it is only the mother. (JF9)

Seeking safety for the family

The home visit with the PHN was described as a positive experience that helped to enhance safety the first few days after returning home from hospital. One father highlighted the importance of health personnel coming home to the family: "I think it was good, and I think it was nice to be able to ask some questions. It makes you feel safe, having such competent people come to your home … yes, and I felt it was a little more on our terms then" (JF6).

One father stated that his positive experiences with the PHN at the home visit helped to lower the threshold for contacting her in the future if needed: "I wouldn't mind calling her if I was wondering about anything … and I don't think it would be difficult to get help either" (IF2). The same father said that the PHN brought up things he had not thought of and that she explained why the baby did different things and how the parents could help stimulate the child's motor and cognitive development. It gave the father a feeling of security and he was confident that the PHN would inform the parents if anything was wrong or if the baby needed extra follow-up. He also experienced that it was nice when the nurse talked about things the baby already was mastering and when she pointed out everything that was positive about the baby.

Another first-time father who for various reasons did not have access to support from his own family, expressed that an available CFHC service that clearly signalized that they were a low-threshold service was very important to him, especially during the initial phase after returning home from the hospital. This provided safety and gave the father a feeling that the first weeks at home with his new-born child had gone very well:

> If something happens or we have a problem, we can drive for five minutes and we are at the CFHC and there is both a PHN and a midwife. You always have someone there if you have any questions, I think that's good. I don't know what it would have been like if we had lived in another municipality or far from the CFHC … I think it would have been difficult. (JF3)

Longing for care

Feeling equal was highlighted as important in the encounter with the PHN: "She asks how I feel about the baby and how I experience things … she asks and maybe she cares too—it seems that way at least … she is nice to talk to … she listens when I talk, she seems very nice" (IF2).

In the joint interviews 1–2 weeks after birth, several parents reflected on mental health and the importance of the mother and father having a conversation with professionals about the topic and extra follow-up if needed. One of the fathers described how he reacted when the topic came up at the home visit with the PHN:

> Then the postpartum depression issue came up, and the PHN asked if I had been depressed before, and I thought that was a bit surprising. Suddenly, there was something that concerned me, or she wanted to investigate whether we were in the risk group … but it is nice to feel equal in a way. It was a bit uncomfortable to be asked, but it was nice. (JF6)

Although the men described it as wonderful to be a father, some fathers reported not being prepared for their own emotional reactions related to pregnancy, childbirth, and the postnatal period. Some of the fathers in the study were concerned about paternal postnatal depression and one father expressed disappointment and a sense of injustice at not being offered help and follow-up relating to his mental health:

> I just haven't been thinking about it, but I am pretty sure that I got into a depression with the first child and that it has kept going on. She (the PHN) didn't talk much about my mental health, but she talked with the mother about her mental health, and then I automatically thought that "OK – I actually feel the way she describes" … no one has offered me anything. It feels quite wrong. (IF8)

This second-time father described how he became aware that he was depressed and probably had been so since his first son was born three years ago while listening to the conversation between his wife and the PHN at the home visit. He had never been asked by the PHN how he had experienced the transition to fatherhood and how this had affected his mental health.

When returning to the theme in the individual interview when the postnatal period was over, none of the fathers had been asked how they felt emotionally or had been offered any kind of mapping of their mental health by the PHN, and some said that they regretted not having a dialogue with the PHN regarding their emotions and mental health:

> I would have liked to fill out such a form (Edinburgh Postnatal Depression Scale - EPDS) about my mental health – or, I would have felt a little more taken care of then … yes, in a good way! Felt that someone was looking after me as father as well. If I had the opportunity to fill out a form and have a conversation, I would have thought it was perfectly fine. (IF9)

Pleasantly surprised was the description a second-time father used when talking about how he reacted when the PHN in the home visit with child number two approached him as a father to find out how he was doing. He expressed that he wished he had been asked what it was like to be a father again and pointed out that both the PHN and the midwife should have asked more about how fathers feel during the postnatal period: "They should have asked more about how the fathers are doing … I would probably say that all was well—but I know now—and I have known that from the first child, that I struggle a little with the role of fatherhood, to adapt" (JF8).

Fathers who had experienced that the PHN included them in the conversation and asked how they were doing and listened to them, felt that she cared for them too. Thus, the fathers' who felt that they knew the PHN, expressed that the relationship was important for their feeling of safety and for mastering the parental role.

Some fathers talked about the couple relationship both in the individual and joint interviews. Especially the first-time fathers were concerned with the changes that might occur when going from being lovers to becoming a family with a baby, which requires most of the parents' time and attention. Taking care of each other and cultivating the relationship was something they wanted to give high priority. Nevertheless, one father said, when the postnatal period was over, "It feels like it's a state of emergency in the relationship, we hold our breathe a bit. We are mom and dad for a while, not lovers. Finding time to take care of ourselves is more restricted" (IF6).

Discussion

The aim of the present study was to describe fathers' expectations of and experiences with municipal postnatal health care in Norway. The essential meaning of going blindly revealed that new fathers in our study entered the postnatal period with a lack of knowledge about what kind of care and follow-up the family would receive from the PHN and the CFHC during the first weeks at home with a newborn baby. This made it difficult knowing what to ask for and what to expect as a father. Because they did not get sufficient information about what was going to happen in the consultation with the PHN at the CFHC, and having the impression that the postnatal health care was primarily an offer for mother and child, the fathers felt like they were going blindly into the women's world. Our findings illustrate that fathers perceive parenting as a teamwork where parents are dependent on each other to give the baby best possible care. The fathers see themselves as an important caregiver and wants to be present in the child's life from the very beginning. Fathers being involved with their children contribute to better health outcomes not only for their partners and children, but also for themselves in being more involved as fathers (Plantin et al., 2011; Sarkadi et al., 2008). The more the father engages himself during the postnatal period, the stronger his attachment will be to his baby and he will participate more during childhood (Plantin et al., 2011). The PHN and the CFHC are expected to provide care and support for the new parents, contribute to early attachment to the infant and facilitate mastery of the parenting role. Despite the fathers' views regarding their significance for the family and the CFHC's overall goal during the postnatal period, this study reveals that the fathers' find that they do not have the same access to the CFHC and postnatal health care as the mother. The health service's lack of support for the parents' perspectives on the child as a joint project might contribute to undermining the couple relationship and the "family project".

In a caring science perspective, caring is something natural and fundamental (Eriksson, 2002). According to Eriksson (2002), all caring is formed and arises in the relationship between a person in need of care and a caregiver. In a caring relationship, the caregiver sees the other person as a unique human being, an entity of body, soul, and spirit. The fundamental idea of caring is the alleviation of suffering and the preservation of life and health (Eriksson, 1987). With such a perspective, compassion and caring for another human being arises in the encounter and in a relationship characterized by responsibility and the desire to do good. When feeling left out by the PHN and experiencing not having the same access as the mother to the postnatal health care, the basis for establishing a caring relationship is difficult. Experiencing absence of care or neglect from the health care professionals can cause unnecessary suffering (Kasén et al., 2008). A study of new mothers' experiences of postpartum care, showed that caring in the postpartum period was experienced as "confirmatory moments of communion" which was recognized even more strongly when experiencing the absence of care (Bondas-Salonen, 1998).

Several fathers in our study described that they had felt the PHN did not expect them to accompany the mother and child to check-ups at the CFHC. This contributed to the fathers' feeling insignificant and excluded in a world where care and follow-up was offered "*by* women *for* women". This finds support in a study of first-time fathers' experiences of support from child health nurses showing that fathers' general perception of being supported was associated with getting necessary information, practical advice when needed, and being reassured (Hrybanova et al., 2019). Because they had not been offered this kind of support, the fathers felt that the nurses treated them unequally compared to the mothers. Despite a greater focus on promoting a more gender equal society and providing the parents with the same opportunities in maternal and child health services, studies have shown that fathers often feel left out and ignored by the health care professionals (Johansson et al., 2013; Pålsson et al., 2017; Wells, 2016). Lacking knowledge and not being able to take part in the consultations at the CFHC were described by one father in the present study as if the mother had a "monopoly" over the child's health and development. All information and communication regarding the baby took place between the mother and the PHN, which left the fathers with a feeling of being left out. The feeling of being excluded was also related to the fathers' experience of not having the opportunity (due to work) to take part in consultations at the CFHC, for example, when the baby's motor and cognitive development was assessed. Not being a part of these common observations between the mother and the PHN, where the mother had the opportunity to ask questions and get advice and guidance related to stimulation and interaction with the child was perceived by the fathers as unjust. Hrybanova et al. (2019) also highlights that the child health nurses' support should be made more available and adapted to the fathers, and that a better organization of the supporting activities (consultations, visits, and groups) is needed. The fathers' need for adapted information is supported by Darwin et al. (2017) as a common desire among fathers. In line with our findings, there was a proclaimed desire to learn from other fathers' experiences in addition to written and online resources. The fathers in the present study expressed that they would welcome a CFHC group for new fathers' in which they could share experiences as fathers and have the opportunity to talk about topics that concern them in connection with the pregnancy, birth and postnatal period. Such a group offer was also seen as network-building and had the potential to prevent loneliness when fathers later went on paternity leave. Alstveit et al. (2010) found in their study of maternal support in maternity leave, that the social relationship with other mothers seemed to be the most important kind of relationship for the first-time mothers. It was proposed (Alstveit et al., 2010) that the CFHC should give all first-time mothers an opportunity to participate in peer support groups in order to strengthen their social relationships.

Safety was important for the new fathers during the first days and weeks after discharging from hospital. Especially the first-time fathers described the overall well-being of the mother and child in addition to an available health care service as significant in order to feel safe and confident at home. In our study, there were various experiences of contact and support from the PHN during the postnatal period and depending on how the fathers had experienced the relationship, an attitude emerged towards the service offer. The fathers who had experienced having little or no contact with the PHN and the CFHC were generally less satisfied, while the fathers who felt more included and familiar with the PHN said that they were more satisfied with the offer that they and the family had received in the postnatal period. However, the fathers highlighted the importance of the home visit and the first meeting with the PHN after returning home from hospital and expressed that it felt safe and reassuring having a professional coming home in a phase when everything was new and both parents felt insecure. Being given the opportunity to ask questions and being listened to as an individual person in a safe and familiar atmosphere at home gave the fathers' a sense of security. This is supported by Persson et al. (2012), where fathers stated that participation during early parenthood, being together as a family and knowing who to ask when in doubt, were essential needs for their sense of security. In addition, being acknowledged and listened to by the health professional gave a sense of participation, which in turn gave a sense of security. The present study reveals that the fathers' who felt involved and "seen" in the encounter with the PHN, felt that she cared for them too. Being together in a caring encounter is to be there as unique in mutuality (Holopainen & Hakulinen, 2019). Although it is the PHN's responsibility to facilitate the encounter particularly through her attitude and demeanour, an elementary understanding of "what it is like" for the fathers from their lifeworld perspective is an important starting point for the PHN in building a caring relationship. Todres et al. (2014) describe the importance of understanding and appreciating a person's "insiderness" and see it as one important dimension in what it takes to "humanise care". Furthermore, as we found in our study, caring for "insiderness" needs to be given more attention. What does it mean for the PHN to understand the "insiderness" of the fathers and how to meet and act on this in caring ways? Todres et al. (2014) propose as one implication for practice that "reaching towards" another person's "insiderness" as a practice and process is often more important than knowing the details of the person's "insiderness" and that this care calls for lifeworld knowledge and "reflective openheartedness".

The feeling of "going blindly" is an image portraying the interviewed fathers' experiences of missing out on information about the offer of the CFHC, a lack of knowledge about children's health and development, and missing communication with the PHN. The core concepts of family-centred care (FCC) include information sharing, participation, collaboration, dignity, and respect (Coyne et al., 2018). In this approach, the family is viewed as a unit and the partnership between the family and the healthcare provider is a core characteristic. Our study indicates that fathers do not experience that the PHN and CFHC focus on the family as a unit in the postnatal period. According to the national guidelines (Norwegian Directorate of Health, 2019), the dialogue between the PHN and the parents must constitute the basis for providing and receiving adequate health care, guidance and support in the postnatal period. Furthermore, as a starting point in all the contacts, the PHN is supposed to map any topics that the parents may want to address and to offer care and support in collaboration with the family based on their needs and the child's health, development and living conditions. In contrast, our study reveals that most of the fathers experienced that they were treated like second rate parents because the focus was almost solely on the mother and child's health and well-being. This is in line with the work of Wells (2016) who found that many Swedish fathers found that they did not receive the amount and types of support from the child health field that they wanted, and that they were not recognized as a "full parent". On the other hand, in our study there were some fathers who had experienced that the PHN was inclusive, listened and showed genuine interest in how they were doing in the role as father. These were aspects that were deemed important in building a trustful relationship with the PHN and gave the father a feeling of being cared for in his first weeks of fatherhood. This act might be seen as the PHN reaching towards the new fathers "insiderness" by inviting herself into his lifeworld (Todres et al., 2014).

The present study indicates that while striving for safety for their family, being seen and taken care of by the PHN seems important for the fathers in the postnatal period. One of the fathers described how he struggled to adapt to fatherhood, and stressed the importance of PHNs and midwives asking both first- and second-time fathers how they are doing in the postnatal period and how they have experienced the transition to fatherhood. Chin, Hall et al. (2011) found in a study of fathers' experiences of their transition to fatherhood that fathers should be encouraged to reflect on their relationship with their own parents and their childhood during the antenatal period, because this could influence their parenting style in a positive way. The same study highlighted the need for practitioners to discuss both positive and negative changes in the couple relationship with the new parents, because some fathers had not expected the more "negative" changes. The postnatal period represents a vulnerable phase for the individual and relational well-being and is associated with increased stressors and demands. This knowledge stresses the importance of understanding the different factors contributing to a healthier or more stressful postnatal period. The individual role satisfaction of the parents is found to be a key factor that may underlie the reduced function of relationships observed in the postnatal and child-rearing period (Cohen et al., 2019).

Most of the fathers in the present study expressed a longing for care in connection with their emotional well-being. Several of the participants in our study were concerned about postnatal depression and it was experienced as an inequality in the health care offer when the fathers were not provided EPDS-screening (Cox et al., 1987) and a conversation about their mental health at the end of the postnatal period. Preventing parental depression is important in postnatal care of the family (Holopainen & Hakulinen, 2019) and thus, the mother and the father's well-being and mental health should be addressed during the home visit after birth and be a recurring theme in all consultations to ensure a good and safe upbringing for the child. Results from a recent study on mothers' and fathers' lived experiences of postpartum depression and parental stress after childbirth have concluded that parental stress and depressive symptoms have a significant impact on the parents' everyday life and interaction with the child (Johansson et al., 2020).There is also a considerable body of evidence (Kingston et al., 2012; P. Ramchandani et al., 2005; P. G. Ramchandani et al., 2008) showing that children of depressed parents represent a high-risk group in terms of medical and psychiatric problems that can debut early and continue through adulthood. This indicates the importance of health professionals' knowledge to identify and support both parents with these conditions in the postnatal period.

Strengths and limitations

By adopting a reflective attitude, the authors have continuously discussed the pattern of meaning that emerged throughout the analysis process, with a focus on scrutinizing our understanding in order to remain open to see in a new way and not merely confirm what is already known (Dahlberg et al., 2008). The focus of the analysis has been meaning-oriented, and the essence of the phenomenon is described on an abstract level; according to Van Wijngaarden et al. (2017), providing an essential meaning structure is considered a core-strength of phenomenological inquiry and implies a certain generalizability of the findings. Another strength of the study is that one researcher (B.K.H) conducted and transcribed all the interviews in addition to being responsible for the analysis. Women and men who have just become parents are in a vulnerable situation. This became visible in the joint interviews conducted one to two weeks after giving birth, when the parents became tired or lost focus because the baby was frequently the dominant object of their attention. This resulted in some interviews being slightly shorter than others. Moreover, one of the individual interviews was short and lasted only for ten minutes. This was mainly because the father had not been in any contact with the CFHC or the PHN during the postnatal period and therefore was unable to share more than just a few experiences of the phenomenon. However, this might be seen as a finding in itself, and even short lifeworld interviews can contribute to nuances in descriptions. The interviews were conducted in safe surroundings in the homes of the families, also resulting in some disturbing factors in the data collection such as the baby crying, older siblings returning home from kindergarten, and telephone calls. These interruptions might have influenced the conversation and the fathers' ability to concentrate and reflect, and thus can be seen as limitations in the study. The presence of a partner has the potential to either enhance or limit the richness of the data collected (Taylor & De Vocht, 2011). In some cases, the mother was more active than the father in the joint interviews and might have dominated the discussion. On the other hand, by conducting the joint interview first, the individual interview became a new opportunity for the fathers to bring out their own lived experiences. The fact that the interviewer was a woman interviewing men about their lived experiences during the postnatal period might be a weakness. At the same time, it may be a strength that the interviewer is a PHN with experience in talking to men about having children and becoming a father. In this study no immigrant fathers were included, and the results therefore may not include the same experiences for these fathers. The study findings reflect a Norwegian context and a homogenous group of fathers in terms of education and being employed, and this may limit the transferability as fathers' expectations and experiences of postnatal health care might depend on the culture that one is familiar with.

Conclusion and implications for practice

This study illustrates that fathers' expectations of and experiences with municipal postnatal health care must be seen as going blindly into the women's world. Little or no knowledge about the CFHC offers makes it difficult to know what to ask for and what to expect. The fathers in our study feel excluded by the PHN and CFHC, a feeling which is reinforced by an impression that the CFHCs postnatal healthcare is primarily an offer provided by women to woman and their babies, seen by the father as a mother–baby–PHN triad. In our study, safety is experienced as important in the initial phase of the postnatal period and in their pursuit to safeguard the new family, the fathers long for support and care from the PHN and CFHC. Caring for the new father by reaching out to his "insiderness" and inviting oneself into his lifeworld, the PHN might help to prevent this feeling of blindness when the father encounters the postnatal period. Our study provides important knowledge that can contribute to a more inclusive, gender-equal and family-centred postnatal care in the municipalities. Based on the interviewed fathers' experiences, both written and oral information about the PHN role and the CFHC offer in the postnatal period should be given to both parents before the birth to enhance their feeling of security when leaving the hospital. The feeling of exclusion and inequality might be avoided by focusing on the mother's and the father's individual follow-up needs and by seeing the newborn baby and the parents as a family unit. The concerns about paternal mental health and emotional reactions connected to pregnancy, birth and postnatal period can be seen as a signal to the municipal postnatal health care and the CFHC that new fathers psychological wellbeing must be addressed to a greater extent. Inclusion of fathers in postnatal care might be vital for development of the family, and for future generations.

More research is needed on multicultural and vulnerable fathers' experiences in the encounter with the PHN and CFHC in the postnatal period. Furthermore, the study raises questions about PHN's perspectives and organizational perspectives on the CFHC regarding inclusion of fathers in postnatal care.

Acknowledgments

We would like to thank the fathers for sharing their experiences in this study, and all those who helped in the recruitment.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The study was supported by the University of Stavanger, Norway.

Notes on contributors

Bente Kristin Høgmo is PhD-student in Health and Medicine at Faculty of Health Sciences, University of Stavanger, Norway. Areas of special interest are postnatal care, promoting health in a family context and development of preventive and health promoting work with children and young people in schools.

Terese Bondas is Professor at Faculty of Health Sciences, University of Stavanger, Norway and Adjunct Professor (Methods of Health Research), University of Eastern Finland, Department of Nursing Science. Areas of special research interest are Childbearing – perspectives of families, health care professionals and doulas, development and critique of qualitative methods in theoretical and evidence-based development of practice and meta-synthesis and professional practices and critical perspectives on nursing, teaching and leadership.

Marit Alstveit is Associate Professor at Faculty of Health Sciences, University of Stavanger, Norway. Areas of special interest are promoting health of women and men becoming parents, promoting health of parents and children being immigrants, and development of public health nursing in context of practice and academia.

ORCID

Bente Kristin Høgmo http://orcid.org/0000-0003-1242-5623
Terese Bondas http://orcid.org/0000-0002-1023-6223
Marit Alstveit http://orcid.org/0000-0002-7834-6023

References

Alstveit, M., Severinsson, E., & Karlsen, B. (2010). Obtaining confirmation through social relationships: Norwegian first-time mothers' experiences while on maternity leave. *Nursing & Health Sciences*, *12*(1), 113–118. https://doi.org/10.1111/j.1442-2018.2009.00508.x

Åsenhed, L., Kilstam, J., Alehagen, S., & Baggens, C. (2014). Becoming a father is an emotional roller coaster – An analysis of first-time fathers' blogs. *Journal of Clinical Nursing*, *23*(9–10), 1309–1317. https://doi.org/10.1111/jocn.12355

Barimani, M., Oxelmark, L., Johansson, S.-E., & Hylander, I. (2015). Support and continuity during the first 2 weeks postpartum. *Scandinavian Journal of Caring Sciences*, *29* (3), 409–417. https://doi.org/10.1111/scs.12144

Bondas-Salonen, T. (1998). New mothers' experiences of postpartum care—A phenomenological follow-up study. *Journal of Clinical Nursing*, *7*(2), 165–174. https://doi.org/10.1046/j.1365-2702.1998.00138.x

Boniol, M., McIsaac, M., Xu, L., Wuliji, T., Diallo, K., & Campbell, J. (2019). *Gender equity in the health workforce: Analysis of 104 countries* (Vol. 8). World Health Organization. https://apps.who.int/iris/handle/10665/311314

Brown, S., Small, R., Argus, B., Davis, P. G., & Krastev, A. (2009). Early postnatal discharge from hospital for healthy mothers and term infants. *Cochrane Database of Systematic Reviews*, Issue *3*. https://doi.org/10.1002/14651858.CD002958

Chin, R., Daiches, A., & Hall, P. (2011). A qualitative exploration of first-time fathers' experiences of becoming a father. *Community Practitioner; London*, *84*(7), 19–23. http://search.proquest.com/docview/875531139/abstract/CC1C57DBCCAF4852PQ/1

Chin, R., Hall, P., & Daiches, A. (2011). Fathers' experiences of their transition to fatherhood: A metasynthesis. *Journal of Reproductive and Infant Psychology*, *29*(1), 4–18. https://doi.org/10.1080/02646838.2010.513044

Cohen, M. J., Pentel, K. Z., Boeding, S. E., & Baucom, D. H. (2019). Postpartum role satisfaction in couples: Associations with individual and relationship well-being. *Journal of Family Issues*, *40*(9), 1181–1200. https://doi.org/10.1177/0192513X19835866

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry*, *150*(6), 782–786. https://doi.org/10.1192/bjp.150.6.782

Coyne, I., Holmström, I., & Söderbäck, M. (2018). Centeredness in healthcare: A concept synthesis of family-centered care, person-centered care and child-centered care. *Journal of Pediatric Nursing*, Special Issue *42*, 45–56. https://doi.org/10.1016/j.pedn.2018.07.001

Dahlberg, H., & Dahlberg, K. (2019). Open and reflective lifeworld research: A third way. *Qualitative Inquiry*, *26*(5), 458-464. 1077800419836696. https://doi.org/10.1177/1077800419836696

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective lifeworld research* (2nd ed.). Studentlitteratur AB.

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., & Gilbody, S. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: A qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC Pregnancy and Childbirth*, *17*(1), 45. https://doi.org/10.1186/s12884-017-1229-4

Deave, T., & Johnson, D. (2008). The transition to parenthood: What does it mean for fathers? *Journal of Advanced Nursing*, *63*(6), 626–633. https://doi.org/10.1111/j.1365-2648.2008.04748.x

Duvander, A.-Z., Lappegård, T., & Andersson, G. (2010). Family policy and fertility: Fathers' and mothers' use of parental leave and continued childbearing in Norway and Sweden. *Journal of European Social Policy*, *20*(1), 45–57. https://doi.org/10.1177/0958928709352541

Eriksson, K. (1987). *Vårdandets idé* [In Swedish: The idea of caring]. Almqvist & Wiksell.

Eriksson, K. (2002). Caring science in a new key. *Nursing Science Quarterly*, *15*(1), 61–65. https://doi.org/10.1177/089431840201500110

Fägerskiöld, A. (2006). Support of fathers of infants by the child health nurse. *Scandinavian Journal of Caring Sciences*, *20*(1), 79–85. https://doi.org/10.1111/j.1471-6712.2006.00383.x

Fägerskiöld, A., & Ek, A. C. (2003). Expectations of the child health nurse in Sweden: Two perspectives. *International Nursing Review*, *50*(2), 119–128. https://doi.org/10.1046/j.1466-7657.2003.00147.x

Feenstra, M., Nilsson, I., & Danbjørg, D. B. (2018). "Dad – A practical guy in the shadow": Fathers' experiences of their paternal role as a father during early discharge after birth and readmission of their newborns. *Sexual & Reproductive Healthcare*, *15*, 62–68. https://doi.org/10.1016/j.srhc.2017.11.006

Holopainen, A., & Hakulinen, T. (2019). New parents' experiences of postpartum depression: A systematic review of qualitative evidence. *JBI Database of Systematic Reviews and Implementation Reports*, *17*(9), 1731–1769. https://doi.org/10.11124/JBISRIR-2017-003909

Hrybanova, Y., Ekström, A., & Thorstensson, S. (2019). First-time fathers' experiences of professional support from child health nurses. *Scandinavian Journal of Caring Sciences*, *33* (4), 921–930. https://doi.org/10.1111/scs.12690

Huusko, L., Sjöberg, S., Ekström, A., Hertfelt Wahn, E., & Thorstensson, S. (2018). First-time fathers' experience of support from midwives in maternity clinics: An interview study. *Nursing Research and Practice; Hindawi*, *2018*, 1–7. https://doi.org/10.1155/2018/9618036

Johansson, M., Benderix, Y., & Svensson, I. (2020). Mothers' and fathers' lived experiences of postpartum depression and parental stress after childbirth: A qualitative study. *International Journal of Qualitative Studies on Health and Well-Being*, *15*(1), 1722564. https://doi.org/10.1080/17482631.2020.1722564

Johansson, M., Rubertsson, C., Rådestad, I., & Hildingsson, I. (2013). Improvements of postnatal care are required by Swedish fathers. *International Journal of Health Care Quality Assurance*, *26*(5), 465–480. https://doi.org/10.1108/IJHCQA-08-2011-0052

Kasén, A., Nordman, T., Lindholm, T., & Eriksson, K. (2008). «Då patienten lider av vården»—Vårdares gestaltning av patientens vårdlidande [In Swedish: When the patient suffers from the care – Caring professionals perceptions of patients suffering from caring]. *Vård I Norden*, *28*(2), 4–8. https://doi.org/10.1177/010740830802800202

Kingston, D., Tough, S., & Whitfield, H. (2012). Prenatal and postpartum maternal psychological distress and infant development: A systematic review. *Child Psychiatry & Human Development*, *43*(5), 683–714. https://doi.org/10.1007/s10578-012-0291-4

Nilsson, I., Danbjørg, D. B., Aagaard, H., Strandberg-Larsen, K., Clemensen, J., & Kronborg, H. (2015). Parental experiences of early postnatal discharge: A meta-synthesis. *Midwifery*, *31*(10), 926–934. https://doi.org/10.1016/j.midw.2015.07.004

Norlyk, A., Haahr, A., & Hall, E. (2016). Interviewing with or without the partner present? – An underexposed dilemma between ethics and methodology in nursing research. *Journal of Advanced Nursing*, *72*(4), 936–945. https://doi.org/10.1111/jan.12871

Norwegian Directorate of Health. (2014). *Nytt liv og trygg barseltid for den nye familien. Nasjonal faglig retningslinje for barselomsorgen* [In Norwegian: New life and safe postnatal period for the new family. National guidelines for postpartum care]. Norwegian Directorate of Health. https://www.helsedirektoratet.no/retningslinjer/barselomsorgen

Norwegian Directorate of Health. (2019). *Nasjonale retningslinjer for helsestasjon og skolehelsetjenesten* [In Norwegian: National guidelines for health clinics and school health services]. Norwegian Directorate of Health. https://www.helsedirektoratet.no/retningslinjer/helsestasjons-og-skolehelsetjenesten

Norwegian Centre for Research Data. (2020,October). *Create a data management plan*. Norwegian Centre for Research Data https://www.nsd.no/en/create-a-data-management-plan

Pålsson, P., Persson, E. K., Ekelin, M., Kristensson Hallström, I., & Kvist, L. J. (2017). First-time fathers experiences of their prenatal preparation in relation to challenges met in the early parenthood period: Implications for early parenthood preparation. *Midwifery*, *50*, 86–92. https://doi.org/10.1016/j.midw.2017.03.021

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. SAGE Publications.

Persson, E. K., Fridlund, B., Kvist, L. J., & Dykes, A.-K. (2012). Fathers' sense of security during the first postnatal week —A qualitative interview study in Sweden. *Midwifery*, *28* (5), e697–e704. https://doi.org/10.1016/j.midw.2011.08.010

Plantin, L., Olukoya, A. A., & Ny, P. (2011). Positive health outcomes of fathers' involvment in pregnancy and childbirth paternal support: A scope study literature review. *Fathering: A Journal of Theory, Research, and Practice about Men as Fathers*, *9*(1), 87–102. https://doi.org/10.3149/fth.0901.87

Polak, L., & Green, J. (2016). Using joint interviews to add analytic value. *Qualitative Health Research*, *26*(12), 1638–1648. https://doi.org/10.1177/1049732315580103

Ramchandani, P., Stein, A., Evans, J., & O'Connor, T. G. (2005). Paternal depression in the postnatal period and child development: A prospective population study. *The Lancet*, *365*(9478), 2201–2205. https://doi.org/10.1016/S0140-6736(05)66778-5

Ramchandani, P. G., O'Connor, T. G., Evans, J., Heron, J., Murray, L., & Stein, A. (2008). The effects of pre- and postnatal depression in fathers: A natural experiment comparing the effects of exposure to depression on offspring. *Journal of Child Psychology and Psychiatry*, *49* (10), 1069–1078. https://doi.org/10.1111/j.1469-7610.2008.02000.x

Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement and children's developmental outcomes: A systematic review of longitudinal studies. *Acta Paediatrica*, *97*(2), 153–158. https://doi.org/10.1111/j.1651-2227.2007.00572.x

Sederström, C. (2019). *State of Nordic Fathers*. Nordic Council of Ministers. https://doi.org/10.6027/NO2019-044

Statistics Norway. (2019). *Helse og sosialpersonell* [In Norwegian: Health and social workers]. Statistics Norway. https://www.ssb.no/arbeid-og-lonn/artikler-og-publikasjoner/storre-vekst-i-antall-menn-med-helse-og-sosialutdanning-enn-kvinner

Steen, M., Downe, S., Bamford, N., & Edozien, L. (2012). Not-patient and not-visitor: A metasynthesis fathers' encounters with pregnancy, birth and maternity care. *Midwifery*, *28*(4), 422–431. https://doi.org/10.1016/j.midw.2011.06.009

Taylor, B., & De Vocht, H. (2011). Interviewing separately or as couples? Considerations of authenticity of method. *Qualitative Health Research*, *21*(11), 1576–1587. https://doi.org/10.1177/1049732311415288

Todres, L., Galvin, K. T., & Dahlberg, K. (2014). "Caring for insiderness": Phenomenologically informed insights that can guide practice. *International Journal of Qualitative Studies on Health and Well-Being*, *9*(1), 21421. https://doi.org/10.3402/qhw.v9.21421

Van der Gaag, N., Heilman, B., Gupta, T., Nembhard, C., & Barker, G. (2019). *State of the world's fathers: Unlocking the power of men's care, 2019: Executive summary* (Report). Promundo-US.

Van Wijngaarden, E., Meide, H. V. D., & Dahlberg, K. (2017). Researching health care as a meaningful practice: Toward a nondualistic view on evidence for qualitative research. *Qualitative Health Research*, *27*(11), 1738–1747. https://doi.org/10.1177/1049732317711133

Wells, M. B. (2016). Literature review shows that fathers are still not receiving the support they want and need from Swedish child health professionals. *Acta Paediatrica*, *105* (9), 1014–1023. https://doi.org/10.1111/apa.13501

World Medical Association. (2013). World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. *JAMA*, *310* (20), 2191. https://doi.org/10.1001/jama.2013.281053

Paper II

Received: 12 May 2022 | Accepted: 30 July 2022
DOI: 10.1111/scs.13117

Scandinavian Journal of Caring Sciences

EMPIRICAL STUDIES

Parents' experiences with public health nursing during the postnatal period: A reflective lifeworld research study

Bente Kristin Høgmo MSc, RN, PHN, PhD student | **Terese Bondas PhD, LicHSc, MNSc, RN, PHN, Professor** | **Marit Alstveit PhD, MHSc, RN, PHN, Associate Professor**

Faculty of Health Sciences, University of Stavanger, Stavanger, Norway

Correspondence
Bente Kristin Høgmo, Faculty of Health Sciences, University of Stavanger, Stavanger, Norway.
Email: bente.k.hogmo@uis.no

Funding information
Universitetet i Stavanger

Abstract

Aim: To describe mothers' and fathers' experiences with public health nursing and child and family health centre services in the postnatal period, both as a couple and as individuals.

Method: A phenomenological reflective lifeworld research approach with a descriptive design was chosen. A purposive sample of 10 mothers and 10 fathers were interviewed twice, 1–2 and 6–8 weeks postpartum, using joint and individual interviews. By focusing on being open and flexible, the data were analyzed to elucidate a meaningful structure of the phenomenon.

Results: The findings revealed that parents' experiences with public health nurse (PHN) and Child and Family Health Centre (CFHC) services in the postnatal period are characterised by a longing to be seen and confirmed both as unique individuals and as a family by the PHN. Although an increased need for both lay and professional care is prominent during the postnatal period, the parents drew a varied picture of their experiences demonstrating that the CFHC services are focussing almost exclusively on mother and child.

Conclusion: A public health nurse can contribute to strengthen parenthood and promote the family's health when the focus is on the new baby. Being cared for while learning to care for the baby is pivotal in a phase that involves both joy and vulnerability. This study adds knowledge concerning the importance of both parents being seen and confirmed by the PHN as unique individuals and a family unit in the postnatal period.

KEYWORDS
Child and Family Health Centre, parents, phenomenological, postnatal care, public health nursing, reflective lifeworld research

INTRODUCTION

The focus of this study is parents' experiences of postnatal care provided by the public health nurse (PHN) and Child and Family Health Centre (CFHC) services. An early postnatal discharge of healthy mothers and term babies has become common in many western countries, and the duration of hospital stay after birth is now around 2–3 days or less [1, 2]. A shorter length of stay at the hospital marks a shift from an illness orientation in maternity care to what has been claimed to be a more family-centred approach where all family members can be together, contributing to improved involvement and bonding between father and child [2]. According to the World Health Organisation, a positive postnatal experience is recognised as a goal and defined as one in which women, newborns, partners, parents, caregivers and families receive information, reassurance and support from motivated health workers [3]. In most high-income countries postnatal healthcare services are offered at the hospital of birth and in municipalities. In the Nordic welfare state context, parents are offered parental leave, which also facilitates the participation of both parents in caregiving and taking part in the postnatal healthcare services provided [4]. The services aim to give parents support in their new role, introduce and support breastfeeding and facilitate the parent–child attachment relationships [5, 6]. The present study is part of a larger Norwegian research project investigating parents' experiences with municipal postnatal healthcare services [7].

BACKGROUND

Having a child is a major life event with several consequences for the new mothers and fathers, both as individuals and as a couple. Giving birth is characterised as something normal, and postpartum strain and exhaustion are not unusual [8, 9]. Being together as a family and receiving follow-up care from health professionals, is described important for parents [10–12]. Good parental support from health care professionals is linked to continuity of care, parent participation, individually adapted care and receiving sufficient information [13–15]. The results of a meta-synthesis [16] show that achieving positive motherhood, being seen as individuals and having their own and their baby's needs recognised and met are considered important for woman in the postnatal period. Because the transition to parenthood might have a significant impact on the couple's relationship, relationship quality is important for the well-being of both partners and their children [17]. Living in an emotionally supportive relationship may protect a persons' psychological and physical health and well-being in demanding situations [18]. Despite strong evidence for the importance of fathers' involvement in their children's care from birth [19, 20], fathers report a lack of information and support from health professionals in the postnatal period [21–23]. A synthesis of previous research on father's encounters with pregnancy, birth and maternity care [24] found that most fathers desired supporting their partners and engaging fully with the process of becoming a father. As shown by Wells [25] if the fathers do not receive support in the postnatal period, they are in danger of being estranged from their parental role; this is unfortunate for them as individuals and for the outcomes of the children, families and society. A meta-synthesis of parental experiences of early postnatal discharge concluded that early postnatal discharge might influence the initial process of feeling secure and confident, as parents depend positively or negatively on the postnatal care [10]. However, the majority of previous research is about women's experiences [26–28] and there is a scarcity of knowledge regarding mothers' and fathers' shared and individual experiences of municipal healthcare in the postnatal period.

THE STUDY

Aim

The study aims to describe mothers' and fathers' experiences with the public health nursing and Child and Family Health Centre services in the postnatal period, both as a couple and as an individual.

Design

The research design is qualitative and phenomenological, using individual and couple interviews as a data collection method.

Method

This study is based on a descriptive reflective lifeworld research (RLR) approach [29]. In RLR the focus is on meaning as the essential structure and the methodological principles are openness, flexibility and 'bridling' [29, 30]. Bridling means to slow down the process of understanding, focussing on not making definite what is still indefinite [29]. An open stance is crucial and implies having the capacity to be surprised and sensitive to the unpredicted and unexpected [29]. The data were collected and transcribed by the first author (BKH) and the two co-authors (TB and MA), who are well-experienced qualitative researchers, fostered and took part in the reflective process of analyzing the data. Critical reading and discussions have been of crucial importance, and the researchers have problematised and reflected on taken-for-granted assumptions in order to allow the phenomenon to present itself more fully [29, 30]. This included following the Consolidated Criteria for Reporting Qualitative Research [31].

Study setting and participants

The study setting is Norwegian public health nursing. In Norway, children have the right to essential medical care and check-ups in the municipality where they live [6]. CFHCs provide free of charge, low-threshold and universal health services for children from 0 to 5 years and their families, following a standardised programme with regular consultations. The parents are offered a home visit 7–10 days after birth by a PHN, group consultation at 4 weeks of age and individual consultation when the child is 6 weeks old, both at the CFHC. In Norway, the Edinburgh Postnatal Depression Scale (EPDS) [32] is used by many CFHCs as a method for mapping mothers' mental health and well-being during the 6-week consultation. Although the primary caregivers at the CFHCs are PHNs, an early home visit by a midwife is also recommended. The aim of postnatal healthcare aims to support the parents and facilitate early parent–child attachment and mastery of the parental role. In addition, emphasis is placed on the child's development and the parents' mental health and well-being [6, 33]. In Norway, CFHCs have daytime opening hours and are closed on weekends.

Ten couples (10 mothers and 10 fathers) participated in the study. Two of the parents came from another Nordic country, and the rest of the parents came from Norway. Inclusion criteria were parents with different sexes who had recently become parents, with the mother discharged from the hospital within 3 days after birth with a healthy baby and no need for additional follow-up from health care professionals. Both parents were required to have mastered a Scandinavian language and planned to utilise CFHC services (see Table 1 for the characteristics of the participants). The recruitment of participants was done with the help of midwives at one hospital, and from midwives at a CFHC in one county in the southwestern region of Norway. In addition, two couples were recruited by snowball sampling. The participants had different occupational backgrounds and worked in health and social care, the oil industry, in kindergartens, as mechanics, electricians, craftsmen and in research.

TABLE 1 Characteristics of the participants ($n = 20$)

Gender	Women	Men	
	10	10	
Age			
Min-Max	24–33	24–33	
Living status			
Living with the mother/father of the child	10	10	
Children			
First child	6	6	
Second child	4	4	
Home visit			
Public health nurse	10	9	
Midwife	6	6	
Four-week check-up at CFHC	8	0	
Group	5	0	
Individual	3	0	
Six-week check-up at CFHC	10	3	
EPDS-mapping	8	0	
Family place of residence			
Urban area (100,000 +/−)			Three families
Rural area (20,000 +/−)			Seven families

Data collection—joint and individual interviews

As lifeworld research does not seek preconceived answers [29], the interview was carried out with a focus on establishing a dialogue that enabled a common reflection on the parents' experiences. The parents were interviewed twice, and the data consist of verbatim transcriptions from semi-structured interviews with ten couples. The joint interviews give the parents the opportunity to negotiate and jointly construct their responses [34], although in some cases one partner might dominate the interview and silence the other [35]. As researchers, it is important to be reflexive during the research process and be aware of potential risks to respondents and consider how our choice of data collection method may affect both the interpretation and analysis of the data, and the well-being of the participants and their relationships. By using this multi-level approach, we incorporated a form of triangulation where the individual interviews gave an opportunity to follow up on topics discussed in the joint interview and create a room for reflection between the joint and individual interviews. By looking at both dyadic and individual perspectives as units of analysis, there is a potential to gain a rich picture of the phenomenon under inquiry [36, 37].

The first interview was a joint interview conducted shortly after returning home from the hospital after birth, and the second was an individual interview at the end of the postnatal period. In the joint interviews, some questions were for common reflection, like: 'can you please describe how you have experienced the postnatal period so far' and 'what do you know about the CFHC service and how did you get this knowledge?' and others were directed at the mother or father, like: 'if you have been in contact with the PHN or CFHC, what are your experiences with the service?'. Some of the joint interviews were characterised by the mother being the most talkative, but there were also interviews where the father's voice dominated, and in these cases, the interviewer deliberately tried to include the other informant by asking questions about his or her experiences, perspectives and opinions. The interviews were conducted and transcribed verbatim by the first author from autumn 2019 to spring 2020. All parents chose their homes as the setting for the interviews. There were in total 30 interviews lasting between 10 and 60 min, with an average length of 35 min.

Analysis

The RLR approach guided the analysis [29]. Based exclusively on the collected data, the aim was to describe the phenomenon without seeking the interpretation [38]. The first author (BKH) analyzed the data under the supervision of the co-authors (TB and MA) who read excerpts from the extracts. The focus was on being open and flexible, striving to have a bridled attitude while seeing each part of the text in terms of the whole while simultaneously understanding the whole in terms of its parts. Following the movements of the text, the first author emphasised being present with the data as given by the parents in the lifeworld interviews, aiming at understanding the text on its own terms. To be open and receptive to the phenomenon under study, we reflected upon our preunderstanding shaped by our theoretical backgrounds, international professional experiences as PHNs and being mothers. Throughout the analysis, we repeatedly discussed alternative meanings to a given meaning unit, and based on differences and similarities, meaning units were clustered together. The clusters of meaning were re-read, and the process continued through common reflection by carrying on a dialogue with the text until a pattern in the clusters appeared. Eventually, the essential meaning structure and the constituents of the phenomenon emerged. Quotes from the joint (J) and individual (I) interviews were coded with numbers and presented under each quotation. The process is illustrated in Table 2.

Ethical considerations

The Regional Committee for Medical and Health Research Ethics West (reg. no: 2019/7220) and the Norwegian Centre for Research Data (NSD) (project number: 420055) approved this study, and the ethical considerations are based on the principles in the Helsinki Declaration [39]. According to NSD's template, a data management plan was prepared [40]. Informed consent was obtained from all participants, and they received both oral and written information on the study and were ensured of their right to withdraw from the study at any time.

FINDINGS

The essential meaning structure of parent's experiences with PHN and CFHC services in the postnatal period is characterised by the parents longing to be seen and confirmed as unique individuals and as a family by the PHN when learning to care for the baby. While striving to get to know and care for the newborn, the parents simultaneously focus on taking care of their own and older children's well-being, and try to relieve and support each other. An increased need for both lay- and professional care is prominent, and the mothers and fathers want to be seen and met by the PHN, and get confirmation that they are good enough as parents. The home visit enables the PHN

TABLE 2 The three phases of the data analysis Dahlberg et al., [29]

Phase 1		Phase 2	Phase 3
Reading/rereading of transcripts		Clusters of meaning	Gathering clusters of meanings in patterns
Extract from interview	Content	Meaning unit	Constituent
'I feel that my need for security and care is much greater than usual. The vulnerability comes out very clearly [...] one is in a way a bit bare—one needs a little care' JM6	Having a baby has made the mother more vulnerable and in need of care	Experiencing increased vulnerability in the initial postnatal period	Feeling a bit skinless with an increased need of care
'The first few days after we got home, I probably stressed a little extra with breastfeeding. There was a lot of hormones and little sleep' JM9	An experience of increased stress the first days at home with a newborn baby		

FIGURE 1 Overarching theme and constituents of parents' experiences with public health nursing and CFHC services in the postnatal period.

to become acquainted with the family and gives insight into their lifeworld. The home visit contributes to safety and lay a foundation for further collaboration between the PHN and the parents. The parents draw a varied picture of their further contact and experiences with the PHN, demonstrating a perception that the CFHC services are focussing almost exclusively on the mother and child. A further description of the phenomenon is followed by its four constituents: *Feeling a bit skinless with an increased need for care, Missing a dialogue about parenthood and family, Home visit as a family experience on the parents' premises and Mother is the messenger*. Overarching theme and constituents are illustrated in Figure 1.

Feeling a bit skinless with an increased need for care

Even though having a baby was described as a joyful experience, a vulnerability associated with establishing oneself at home as a new family was prominent in the initial postnatal phase. One mother described that she had a greater need for security and care and by using the metaphor 'skinless' she talked about the vulnerability she experienced the first days after returning home after birth. The parents emphasised that the care from family and friends was significant, and for the parents who lacked family support, CFHC played an important role in terms of providing extra professional care and being an arena contributing to establishing relationships with other parents: *'I have been there twice a week, the maternity group at the CFHC has meant a great deal to me' (JM3).*

The interviews revealed a distinct difference between how the mothers and fathers experienced the follow-up from the PHN. One father stated: ***'I haven't been in contact with the CFHC after the home visit. The mother has been there during the postnatal period, but I don't think it was expected that I should come' (IF8)***. The mother, on the other hand, said that the PHN had been essential for her during the postnatal period, especially in relation to her mental health. Several parental couples reflected on how their well-being mattered to the baby. Childbirth and postpartum were described as a journey through the physical and psychological, from chaos to stabilisation and normality. In this phase mental health was something that concerned the parents.

> The six-week check-up was in her (PHN) office where we sat down and went through this screening for postpartum depression. Then we got much more into how I actually felt, and that was perhaps why I also got a stronger feeling of making contact with her.
> (IM6)

The fathers were not offered a conversation about their mental health and well-being when the postnatal period was over: 'I would like to tell the PHNs that they must invite both parents to the six-week check-up. That both parents have to come! I think it would have been good for men too, to fill out such a form about their mental health' (IF8).

Missing a dialogue about parenthood and family

Taking care of the baby, older siblings and each other was something the parents' described as particularly important. Having a child was perceived as a joint project, which creates a mutual dependency between the parents. Through the parents' reflections, a perception of a missing family perspective was revealed. This was expressed through statements related to the parents' experience that the PHN's intentionality was mainly directed at the mother and baby. Having this mother–child focus was described as natural and reassuring, but at the same time, the parents expressed that they missed being seen more as a unit in which all family members play a role in 'the becoming of a new family'.

Several parents said that even if you try to prepare as best you can, you will never fully know what it means to be a mother or father before the baby is born. In the joint interview, a parental couple had a dialogue about the change that had happened to them as individual persons when becoming parents:

> Then we became in a way two new people. Before, we were just ourselves, really ... and now we are actually parents. It's a whole new role that you suddenly have—which comes very overnight, really [...] we must get to know each other again.
>
> (JM2)

One of the fathers described how life had changed after he became a father, and while reflecting on the topic he suddenly realised that their new roles as parents had in a way displaced their previous roles as a loving couple and that it had been a bit challenging.

A longing to be confirmed as a unique individual was expressed through the parents' descriptions of a lack of focus on the father and his significance for the baby and the rest of the family in the postnatal period.

> Going from being a couple to becoming parents is a big change. And I think there are many relationships that break up because mom feels that dad is not contributing enough. So, I think it's important ... to see dad more. Perhaps several relationships could have been saved then.
>
> (IM10)

Home visit as a family experience on the parents' premises

The home visit was perceived by the parents as a family experience, and the establishment of contact with PHN in the home environment contributed to increased security. The home visit was described as concrete care and attention and experienced by the parents as being met more on their own terms. 'It has been great to get the first follow-up at home. It is very nice to have your own PHN which you are followed up by and which you can contact if there is anything, in addition to the regular checks' (JM6).

In the encounter with the health personnel at the hospital, the parents felt more like recipients while in their own home environment they experienced a shift in the balance of power and became more active participants. Information about what should happen in the future, such as which check-ups and vaccines were planned for the baby, was described as important for the parents to grasp as early as possible. Being seen, listened to and taken seriously gave the parents increased security in mastering the care and nurturing of their baby. The fact that both mother and father could ask questions and receive evidence-based answers was emphasised as important by several parents.

> She stayed here a long time and I did not feel that I delayed her. She took her time and answered all our questions. She was just really good and calm in relation to everything and ... I did not feel stupid when I asked about things.
>
> (IM2)

Support, recognition and professionalism invited a trusting relationship and helped to lay a good foundation for further cooperation between the parents and the PHN.

Mother is the messenger

Several mothers said that they had developed a trusting relationship with their PHN and experienced they were followed up systematically. At the same time, some mothers expressed that they perceived that the fathers were not given the same opportunities and were not incorporated to the same extent in consultations with the baby.

> As a mother I have not missed anything, but I think they (PHNs) must see father to a greater extent. I've been thinking about how they can handle it when I am the one who always goes to the CFHC, and the father is at work. Then it becomes the mother's role to be a messenger.
> (IM3)

In the couple interviews, one mother and father became aware of some mechanisms that may have contributed to the father feeling excluded, such as the fact that the mother unconsciously viewed the contact with the PHN and CFHC as a 'mother task'. Several fathers described that they felt excluded by the PHN and the CFHC services. They experienced that the flow of information and contact solely took place between the mother and PHN, and some of them also expressed that they perceived that the CFHC was primarily a mother–child offer. One first-time father said:

> It can be a little difficult for the father as well in the beginning. All contact with PHN and CFHC goes through the mother, as a father you just have to follow. It has gone well for me, I like that the mother has some control, but the PHN and CFHC could have included me as father more.
> (IF5)

Accessibility, content and mandate were areas that occupied the fathers, and they shared views related to the service's opening hours, information exchange and the way PHN and CFHC communicated with the parents.

DISCUSSION

The postnatal period was experienced by the parents as both joyful and challenging. For the parents who lacked support from their families, the care from PHN was perceived as pivotal. Other studies of parents' experiences and needs postnatally have also identified the increased need for practical and professional support, information and care [8, 9]. The maternity groups offered at the CFHC contributed to build social relationships and were appreciated by the mothers. Previous studies support that maternity groups can create a basis for establishing networks for new families and facilitate PHNs to conduct health-promoting work [41, 42].

In this study, the parents reflected upon how the transition to parenthood had made visible a great responsibility to take care of themselves and each other when feeling a bit 'skinless', so that they were able to care for the baby. According to Eriksson [43], all human beings are natural caregivers. Based on a caring science perspective, providing care can be seen as an interactive process and an expression of reciprocity as described by the parents. The professional care is therefore not different from the natural one, but it is required to be not only technical but also holistic where the goal is to promote the person's overall health [43]. Our study found that establishing the new family was of major importance for the parents and they wanted to be recognised as equally important caregivers. Confirmation that they were good enough as parents and that everything was going well with the baby was essential. Even though the parents described a strong mutual dependency on each other, a missing family perspective was revealed in the encounter with the PHN. A mother–child focus dominated leaving the father in the 'shadows', which is unfortunate because individualised available support is shown to increase the parents' sense of security and parental confidence [10]. A family is a dynamic unit of unique persons in relation to each other already before the birth of the baby, thus the family in care can not be known only through one of its members [44].

Creating a family is described as demanding in terms of the baby having the main focus at the expense of the couple's relationship and PHN can play an important role in scaffolding the new family. Delicate et al. [17] describe relationship changes due to parents physically being focussed on the baby, leaving partners to feel left out or competing with the baby for affection. Transition to parenthood is a developmental transition, and the concept relates to how the individuals respond to changes they undergo and how new circumstances are incorporated and adopted into an individual's life [45]. The PHN might have an important role in contributing to preventing a relationship breakdown by having a dyadic focus in order to understand how to support the parents to identify and manage potential relational problems. This view is confirmed by Ahlborg et al. [46], who argue that by being aware of the possible strained situation of new parents, the PHN can support both on an individual and group level aimed at facilitating the parent and partner roles by focussing on communication skills and cohesion.

The parents experienced a lack of focus on the father's needs and significance for the baby and described it as adverse that the PHN's focus was only on the mother's mental health. When not feeling supported, fathers might feel unimportant, distant and helpless [25]. This finding is supported by Wiklund et al. [15] who found that a person-centred approach and empowering behaviour in the postnatal period was one of the most beneficial interventions for preventing postnatal depression. They suggest family-centred care as a model that might improve postnatal care for mothers and fathers. In this study, becoming parents is perceived as an exciting period in life, which also represents increased vulnerability. The experience of home visits by PHN was described as a great contribution to increased security and seen by the parents as a family experience. Being able to get advice and guidance in relation to breastfeeding and other relevant issues was considered important and led to increased mastery of necessary skills. The home visit was also considered a good way to get to know each other and prepare the ground for further cooperation. These findings are supported by studies of parents' experiences of homecare, showing that mothers and fathers felt safe in their own home environment, indicating that it might be easier for health personnel to provide high-quality care that optimises the health and well-being of the whole family unit by providing home-based early postnatal care [47–49].

Several fathers described feeling excluded by the PHN and experienced that all contact and information took place between the PHN and the mother. These findings are in line with Hodgson et al. [21], who suggest that the father's needs are not being adequately met by healthcare professionals in the postnatal period. Despite a goal of providing municipal postnatal healthcare that embraces the whole family [33], change within services has been slow. As shown by Wells [25], more pressure is placed on the mothers to manage the child's health care when fathers miss the parent–child opportunities the CFHC services represent. Fathers are longing to be acknowledged as equivalent in the parenting dyad and the perception of support when becoming a father affects father–infant bonding [19]. Treating fathers as equal parents and giving them a participating role may contribute to strengthening their fatherhood identity [50]. Although the phenomenon of maternal gatekeeping may be tied to fathers' involvement and access to postnatal care [51], both fathers and mothers reflected upon how the PHN and CFHC could encourage fathers to participate by offering more flexible opening hours. This is in line with Wells & Sarkadi [52], who point to two main barriers to why CFHC still does not promote father involvement effectively. First, most CFHCs are only open during normal working hours, and second, the PHNs are not doing enough to directly encourage paternal participation.

Methodological considerations

The results in this study are based on a variety of data presented as an essence with its constituents, which is considered a core strength in phenomenological inquiry [29, 53]. The descriptions of the phenomenon have contributed to provide research findings that are generally valid for parents other than those involved in the present study [54]. Using a multi-level approach with a combination of joint and individual interviews, the mothers and fathers were given the possibility to co-create, discuss and individually reflect upon the topics raised in the interviews, which contributed to gaining a broader picture of the parents' lived experiences. Even though both joint and individual interviews have their limitations, the two approaches complement each other in elucidating different aspects of the parents' experiences [55]. One of the individual interviews lasted only for 10 min, mainly because the father had limited experiences due to minimal contact with the PHN and CFHC in the postnatal period, which on the other hand might be seen as a finding in itself. In reflective lifeworld research, even short interviews can contribute to nuances in descriptions and by interviewing the parents twice, illuminated aspects of the phenomenon in the joint interviews were further explored in the individual interviews. The findings in this study reflect a Norwegian context and a homogenous group of parents regarding education, employment and marriage or cohabitation. Future research might also include multicultural parents and parents with additional follow-up needs experiences in the encounter with the CFHC and PHN in the postnatal period.

CONCLUSION AND IMPLICATIONS

Our findings show that the PHN can contribute to strengthen parenthood and promote the whole family's health when the new baby is in focus. In a phase characterised as both joyful and vulnerable, being cared for when learning to care for the baby is pivotal. While the home visit is described by the parents as a good family experience contributing to increased security and mastery, the further contact with the PHN and CFHC is distinguished by most fathers having little or no contact with the service. Although the mothers describe postnatal care that to a large extent meets their needs, a greater family focus is required. The findings of this study expand our knowledge regarding what is important for mothers and fathers in the encounter with the CFHC services, suggesting a further development of postnatal care in order to meet the parents' unique individual needs, promote paternal participation and concurrently recognise the family as a unit where the whole family's health and well-being are important for the parents and their baby.

AUTHOR CONTRIBUTIONS

Bente Kristin Høgmo was involved in the study design, interviews, transcriptions, analyses and manuscript preparation. Terese Bondas and Marit Alstveit were involved in

designing the study and contributed to the analyses and manuscript preparation. All authors have agreed on the final version of the manuscript.

ACKNOWLEDGEMENTS

The authors would like to thank the parents who shared their valuable experiences and all those who helped in the recruitment.

FUNDING INFORMATION

This research was funded by the University of Stavanger, Norway.

CONFLICT OF INTEREST

The authors report no potential conflict of interest, and the authors alone are responsible for the content and the writing of the manuscript.

ETHICS STATEMENT

The Regional Committee for Medical and Health Research Ethics West (reg. no: 2019/7220) and the Norwegian Centre for Research Data (NSD) (project number: 420055) approved this study.

ORCID

Bente Kristin Høgmo https://orcid.org/0000-0003-1242-5623
Terese Bondas https://orcid.org/0000-0002-1023-6223
Marit Alstveit https://orcid.org/0000-0002-7834-6023

REFERENCES

1. Campbell OMR, Cegolon L, Macleod D, Benova L. Length of stay after childbirth in 92 countries and associated factors in 30 low- and middle-income countries: compilation of reported data and a cross-sectional analysis from nationally representative surveys. PLoS Med. 2016;13(3):e1001972. https://doi.org/10.1371/journal.pmed.1001972
2. Jones S, Stewart F, Taylor B, Davis PG, Brown SJ. Early postnatal discharge from hospital for healthy mothers and term infants. Cochrane Database Syst Rev. 2021;6:CD002958. https://doi.org/10.1002/14651858.CD002958.pub2
3. WHO. WHO recommendations on maternal and newborn care for a positive postnatal experience. Geneva: WHO. Available from:; 2022. https://www.who.int/publications-detail-redirect/9789240045989
4. Sederström C. State of Nordic fathers. Copenhagen, Denmark: Nordic Council of Ministers; 2019. https://doi.org/10.6027/NO2019-044
5. WHO. WHO recommendations on Postnatal care of the mother and newborn. Geneva: WHO. Available from:; 2013. https://www.who.int/publications-detail-redirect/9789241506649
6. Norwegian Directorate of Health. Nasjonal faglig retningslinje for det helsefremmende og forebyggende arbeidet i helsestasjon, skolehelsetjeneste og helsestasjon for ungdom [National guidelines for health clinics and school health services. In Norwegian]. Norwegian Directorate of Health. Available from:; 2022. https://www.helsedirektoratet.no/retningslinjer/helsestasjons-og-skolehelsetjenesten/helsestasjon-05-ar
7. Høgmo BK, Bondas T, Alstveit M. Going blindly into the women's world: a reflective lifeworld research study of fathers' expectations of and experiences with municipal postnatal healthcare services. International Journal of Qualitative Studies on Health and Well-being. 2021;16(1):1918887. https://doi.org/10.1080/17482631.2021.1918887
8. Hjälmhult E, Lomborg K. Managing the first period at home with a newborn: a grounded theory study of mothers' experiences. Scand J Caring Sci. 2012;26(4):654–62. https://doi.org/10.1111/j.1471-6712.2012.00974.x
9. Kurth E, Krähenbühl K, Eicher M, Rodmann S, Fölmli L, Conzelmann C, et al. Safe start at home: what parents of newborns need after early discharge from hospital - a focus group study. BMC Health Serv Res. 2016;16:1–14. https://doi.org/10.1186/s12913-016-1300-2
10. Nilsson I, Danbjørg DB, Aagaard H, Strandberg-Larsen K, Clemensen J, Kronborg H. Parental experiences of early postnatal discharge: a meta-synthesis. Midwifery. 2015;31(10):926–34. https://doi.org/10.1016/j.midw.2015.07.004
11. Johansson K, Aarts C, Darj E. First-time parents' experiences of home-based postnatal care in Sweden. Ups J Med Sci. 2010;115(2):131–7. https://doi.org/10.3109/03009730903431809
12. Aune I, Voldhagen H, Welve I, Dahlberg U. Early discharge from hospital after birth: how Norwegian parents experience postnatal home visits by midwives – A qualitative study. Sex Reprod Healthc. 2021;30:34741842. https://doi.org/10.1016/j.srhc.2021.100672
13. Barimani M, Vikström A. Successful early postpartum support linked to management, informational, and relational continuity. Midwifery. 2015;31(8):811–7. https://doi.org/10.1016/j.midw.2015.04.009
14. Entsieh AA, Hallström IK. First-time parents' prenatal needs for early parenthood preparation-A systematic review and meta-synthesis of qualitative literature. Midwifery. 2016;39:1–11. https://doi.org/10.1016/j.midw.2016.04.006
15. Wiklund I, Wiklund J, Pettersson V, Boström A-M. New parents' experience of information and sense of security related to postnatal care: a systematic review. Sex Reprod Healthc. 2018;17:35–42. https://doi.org/10.1016/j.srhc.2018.06.001
16. Finlayson K, Crossland N, Bonet M, Downe S. What matters to women in the postnatal period: a meta-synthesis of qualitative studies. PLOS One. 2020;15(4):e0231415. https://doi.org/10.1371/journal.pone.0231415
17. Delicate A, Ayers S, McMullen S. A systematic review and meta-synthesis of the impact of becoming parents on the couple relationship. Midwifery. 2018;61:88–96. https://doi.org/10.1016/j.midw.2018.02.022
18. Valla L, Helseth S, Småstuen MC, Misvær N, Andenæs R. Factors associated with maternal overall quality of life six months postpartum: a cross sectional study from The Norwegian Mother, Father and Child Cohort Study. BMC Pregnancy Childbirth. 2022;22(1):4. https://doi.org/10.1186/s12884-021-04303-5
19. Scism AR, Cobb RL. Integrative review of factors and interventions that influence early father–infant bonding. J Obstet Gynecol Neonatal Nurs. 2017;46(2):163–70. https://doi.org/10.1016/j.jogn.2016.09.004

20. Shorey S, Ang L, Goh ECL, Gandhi M. Factors influencing paternal involvement during infancy: a prospective longitudinal study. J Adv Nurs. 2019;75(2):357–67. https://doi.org/10.1111/jan.13848
21. Hodgson S, Painter J, Kilby L, Hirst J. The experiences of first-time fathers in perinatal services: present but invisible. Healthcare. 2021;9(2):161. https://doi.org/10.3390/healthcare9020161
22. Høgmo BK, Bondas T, Alstveit M. Going blindly into the women's world: A reflective lifeworld research study of fathers' expectations of and experiences with municipal postnatal healthcare services. Int J Qual StudHealth Well-Being. 2021;16(1):1–13. https://doi.org/10.1080/17482631.2021.1918887
23. Wells MB, Aronson O. Paternal postnatal depression and received midwife, child health nurse, and maternal support: a cross-sectional analysis of primiparous and multiparous fathers. J Affect Disord. 2021;280:127–35. https://doi.org/10.1016/j.jad.2020.11.018
24. Steen M, Downe S, Bamford N, Edozien L. Not-patient and not-visitor: a metasynthesis fathers' encounters with pregnancy, birth and maternity care. Midwifery. 2012;28(4):422–31. https://doi.org/10.1016/j.midw.2011.06.009
25. Wells MB. Literature review shows that fathers are still not receiving the support they want and need from Swedish child health professionals. Acta Paediatr. 2016;105(9):1014–23. https://doi.org/10.1111/apa.13501
26. Aune I, Dahlberg U, Haugan G. Health-promoting influences among Norwegian women following early postnatal home visit by a midwife. Nordic J Nurs Res. 2018;38(4):177–86. https://doi.org/10.1177/2057158517733244
27. Johansson M, Thies-Lagergren L, Wells MB. Mothers' experiences in relation to a new Swedish postnatal home-based model of midwifery care–A cross-sectional study. Midwifery. 2019;78:140–9. https://doi.org/10.1016/j.midw.2019.07.010
28. Persson EK, Fridlund B, Kvist LJ, Dykes A. Mothers' sense of security in the first postnatal week: interview study. J Adv Nurs. 2011;67(1):105–16. https://doi.org/10.1111/j.1365-2648.2010.05485.x
29. Dahlberg K, Dahlberg H, Nyström M. Reflective lifeworld research. 2nd ed. Lund, Sweden: Studentlitteratur AB; 2008.
30. Dahlberg H, Dahlberg K. The question of meaning—A momentous issue for qualitative research. Int J Qual Stud Health Well Being. 2019a;14(1):1598723. https://doi.org/10.1080/17482631.2019.1598723
31. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International J Qual Health Care. 2007;19(6):349–57. https://doi.org/10.1093/intqhc/mzm042
32. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry. 1987;150:782–6.
33. Norwegian Directorate of Health. *Nytt liv og trygg barseltid for den nye familien. Nasjonal faglig retningslinje for barselomsorgen* [New life and safe postnatal period for the new family. National guidelines for postpartumcare. In Norwegian]; 2014. Available from: https://www.helsedirektoratet.no/retningslinjer/barselomsorgen
34. Racher FE. Using conjoint interviews to research the lived experience of elderly rural couples. Nurse Researcher (through 2013). 2003;10(3):60–72.
35. Zarhin D. Conducting joint interviews with couples: ethical and methodological challenges. Qual Health Res. 2018;28(5):844–54. https://doi.org/10.1177/1049732317749196
36. Blake S, Janssens A, Ewing J, Barlow A. Reflections on joint and individual interviews with couples: a multi-level interview mode. Int J Qual Methods. 2021;20:16094069211016732. https://doi.org/10.1177/16094069211016733
37. Norlyk A, Haahr A, Hall E. Interviewing with or without the partner present? – An underexposed dilemma between ethics and methodology in nursing research. J Adv Nurs. 2016;72(4):936–45. https://doi.org/10.1111/jan.12871
38. Dahlberg H, Dahlberg K. Open and reflective lifeworld research: a third way. Qual Inq. 2019b;26(5):458–64. https://doi.org/10.1177/1077800419836696
39. World Medical Association. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. JAMA. 2013;310(20):2191–4. https://doi.org/10.1001/jama.2013.281053
40. Norwegian Centre for Research Data. Create a data management plan. Bergen, Norway: Norwegian Centre for Research Data. Available from:; 2020. https://www.nsd.no/en/create-a-data-management-plan
41. Alstveit M, Severinsson E, Karlsen B. Obtaining confirmation through social relationships: Norwegian first-time mothers' experiences while on maternity leave. Nurs Health Sci. 2010;12(1):113–8. https://doi.org/10.1111/j.1442-2018.2009.00508.x
42. Glavin K, Tveiten S, Økland T, Hjälmhult E. Maternity groups in the postpartum period at well child clinics – mothers' experiences. J Clin Nurs. 2017;26(19–20):3079–87. https://doi.org/10.1111/jocn.13654
43. Eriksson K. *Vårdandets ide'.* [The idea of caring. In Swedish]. Stockholm, Sweden: Norstedts Förlag; 1987.
44. Bondas T. In: Balin R, editor. To be with child: a heuristic synthesis in maternal care. In Trends in Midwifery Research. New York: Nova Science; 2005. p. 119–36.
45. Meleis A. Transitions theory: middle range and situation specific theories in nursing research and practice. New York: Springer Publishing Company; 2010.
46. Ahlborg T, Misvaer N, Möller A. Perception of marital quality by parents with small children: a follow-up study when the firstborn is 4 years old. J Fam Nurs. 2009;15(2):237–63. https://doi.org/10.1177/1074840709334925
47. Askelsdottir B, Jonge WL, Edman G, Wiklund I. Home care after early discharge: impact on healthy mothers and newborns. Midwifery. 2013;29(8):927–34. https://doi.org/10.1016/j.midw.2012.11.001
48. Johansson M, Östlund P, Holmqvist C, Wells MB. Family life starts at home: fathers' experiences of a newly implemented Swedish home-based postnatal care model – an interview study. Midwifery. 2022;105:103199. https://doi.org/10.1016/j.midw.2021.103199
49. Solberg B, Glavin K, Berg RC, Olsvold N. Norwegian fathers' experiences with a home visiting program. Public Health Nurs. 2022;39(1):126–34. https://doi.org/10.1111/phn.12995

50. Pålsson P, Persson EK, Ekelin M, Kristensson Hallström I, Kvist LJ. First-time fathers experiences of their prenatal preparation in relation to challenges met in the early parenthood period: Implications for early parenthood preparation. Midwifery. 2017;50:86–92. https://doi.org/10.1016/j.midw.2017.03.021
51. Zvara BJ, Schoppe-Sullivan SJ, Dush CK. Fathers' Involvement in Child Health Care: Associations with Prenatal Involvement, Parents' Beliefs, and Maternal Gatekeeping. Fam Relap. 2013;62(4):649–61. https://doi.org/10.1111/fare.12023
52. Wells MB, Sarkadi A. Do father-friendly policies promote father-friendly child-rearing practices? a review of swedish parental leave and child health centers. J Child Fami Stud. 2012;21(1):25–31. https://doi.org/10.1007/s10826-011-9487-7
53. van Wijngaarden E, Meide H v d, Dahlberg K. Researching health care as a meaningful practice: toward a nondualistic view on evidence for qualitative research. Qual Health Res. 2017;27(11):1738–47. https://doi.org/10.1177/1049732317711133
54. Dahlberg K. The question of evidence in qualitative research. Nordic J Nurs Res. 2019;39(1):55–7. https://doi.org/10.1177/2057158518807855
55. Taylor B, de Vocht H. Interviewing separately or as couples? considerations of authenticity of method. Qual Health Res. 2011;21(11):1576–87. https://doi.org/10.1177/1049732311415288

How to cite this article: Høgmo BK, Bondas T & Alstveit M Parents' experiences with public health nursing during the postnatal period: A reflective lifeworld research study. Scand J Caring Sci. 2023;37:373–383. https://doi.org/10.1111/scs.13117

Paper III

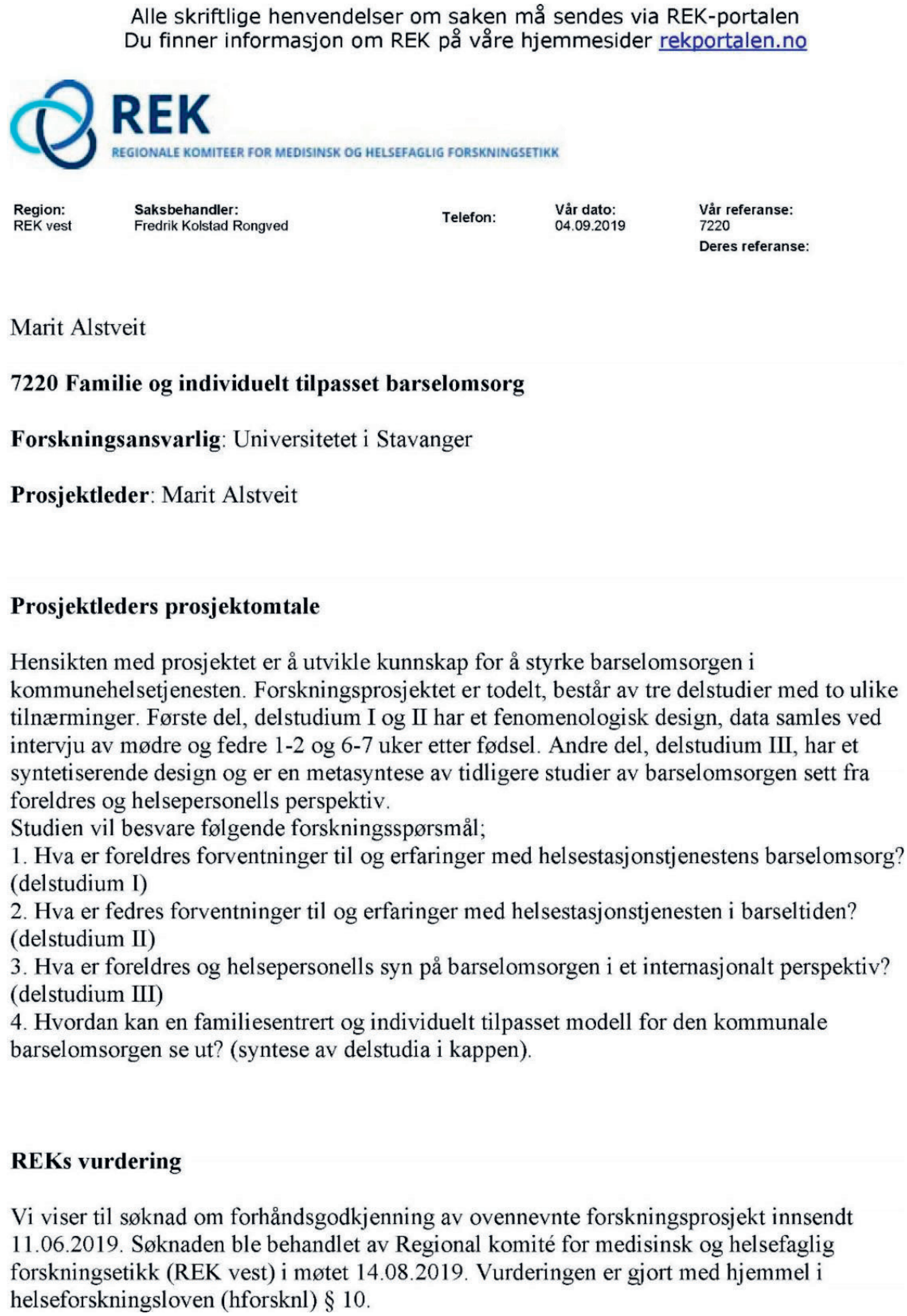
Høgmo, B.K., Alstveit, M. & Bondas, T.

Being "a warrior" to care for the new family - a meta-ethnograpy of nurses' perspectives on municipal postnatal healthcare.

Manuscript submitted and in review.

Appendices

Appendix I - Approval from the regional ethics committee (REK)



Alle skriftlige henvendelser om saken må sendes via REK-portalen
Du finner informasjon om REK på våre hjemmesider rekportalen.no

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Fredrik Kolstad Rongved		04.09.2019	7220
				Deres referanse:

Marit Alstveit

7220 Familie og individuelt tilpasset barselomsorg

Forskningsansvarlig: Universitetet i Stavanger

Prosjektleder: Marit Alstveit

Prosjektleders prosjektomtale

Hensikten med prosjektet er å utvikle kunnskap for å styrke barselomsorgen i kommunehelsetjenesten. Forskningsprosjektet er todelt, består av tre delstudier med to ulike tilnærminger. Første del, delstudium I og II har et fenomenologisk design, data samles ved intervju av mødre og fedre 1-2 og 6-7 uker etter fødsel. Andre del, delstudium III, har et syntetiserende design og er en metasyntese av tidligere studier av barselomsorgen sett fra foreldres og helsepersonells perspektiv.
Studien vil besvare følgende forskningsspørsmål;
1. Hva er foreldres forventninger til og erfaringer med helsestasjonstjenestens barselomsorg? (delstudium I)
2. Hva er fedres forventninger til og erfaringer med helsestasjonstjenesten i barseltiden? (delstudium II)
3. Hva er foreldres og helsepersonells syn på barselomsorgen i et internasjonalt perspektiv? (delstudium III)
4. Hvordan kan en familiesentrert og individuelt tilpasset modell for den kommunale barselomsorgen se ut? (syntese av delstudia i kappen).

REKs vurdering

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt innsendt 11.06.2019. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK vest) i møtet 14.08.2019. Vurderingen er gjort med hjemmel i helseforskningsloven (hforsknl) § 10.

Søknadsplikt:

Komiteen vurderer at prosjektet søker så skaffe til veie ny kunnskap om helse og sykdom, jf. helseforskningslovens (hfl) § 4 bokstav a jf. hfl § 2. Formålet er å styrke barselomsorgen i kommunehelsetjenesten. Dette skal gjøres gjennom å søke kunnskap om behandlingen av foreldre i barseltiden. Dette vil kunne skaffe til veie ny kunnskap om helse og sykdom.

Forsvarlighet:

Intervju med kvinner og menn som nylig er blitt foreldre. De skal intervjues 1-2 og 6-7 uker etter barnets fødsel. Intervjuguide er vedlagt. Det er ønske om å rekruttere 20 deltakere (10 av hvert kjønn). Komiteen vurderer at prosjektet er forsvarlig å gjennomføre i sin nåværende form, men setter vilkår om at prosjektleder sender inn en refleksjon angående de oppsatte eksklusjonskriteriene og et revidert informasjonsskriv.

Eksklusjonskriterium:

Det er oppgitt følgende to eksklusjonskriterier: 1) Foreldre med samme kjønn, og 2) foreldre som ikke bor sammen. Komiteen savner en begrunnelse for hvorfor dette er nødvendige eksklusjonskriterier. Dette vil føre til et design som bare vil undersøke erfaringer og forventninger for den tradisjonelle kjernefamilien. Komiteen ber om at prosjektleder sender inn en begrunnelse for disse eksklusjons- og inklusjonskriteriene.

Informasjonsskriv og samtykkeskjema:

REK vest ber om at informasjonsskrivet revideres i henhold til følgende merknader:

- Logo til forskningsansvarlig institusjon må settes på informasjonsskrivet.
- Informasjon om godkjenning av REK med ref.nr.
- Epostadressen til institusjonens personvernombud må oppgis.

Revidert informasjonsskriv kan sendes til REK vest sammen med en begrunnelse for eksklusjonskriteriene. De kan leveres i «oppgave»-fanen i ny saksportal.

Samarbeid med utlandet?:

Det er ikke angitt planer om samarbeid med utlandet, og informasjonsskrivet åpner ikke for utsending av data til utlandet heller. Komiteen har ingen innvending mot dette.

I protokollen oppgir imidlertid stipendiaten at det foreligger planer om utenlandsopphold i Australia og/eller USA. Dersom hun ønsker å ta data med seg dit og samarbeide med dem med dette datamaterialet, så råder REK vest om å revidere informasjonsskrivet allerede nå slik at det ikke blir en ny runde med utsending av informasjonsskriv senere. Data kan ikke sendes til utlandet basert på samtykke slik det foreligger nå.

Et eventuelt datasamarbeid med Australia og USA vil kreve en del avklaringer i form av avtaler mellom Universitetet i Stavanger og den eventuelle utenlandske institusjonen. Avtalene må institusjonen selv måtte ta ansvar for, men et samarbeid må også søkes om til REK gjennom en endringsmelding.

Prosjektslutt og behandling av data:

Prosjektslutt er satt til 30.12.2023. Lydfiler og personidentifiserbare opplysninger slettes ved prosjektslutt. Det bearbeidede datamaterialet anonymiseres og det vil ikke være mulig å gjenkjenne deltakerne i de publiserte artiklene. Komiteen har ingen merknader.

Vedtak

Godkjent med vilkår

REK vest setter følgende vilkår:

- En begrunnelse for eksklusjons- og inklusjonskriteriene må sendes til REK vest.
- Revidert informasjonsskriv må sendes til REK vest.

Vedtakstekst*:* REK vest har gjort en helhetlig forskningsetisk vurdering av alle prosjektets sider. Prosjektet godkjennes med hjemmel i helseforskningsloven § 10 på betingelse av at ovennevnte vilkår tas til følge.

Med vennlig hilsen
Marit Grønning
Prof. dr.med.
Komiteleder

Fredrik Rongved
rådgiver

Refleksjon rundt eksklusjonskriteriene, svar til REK.

Vi viser til vedtak av 04.09.19, ref. 7220 vedrørende godkjenning av forskningsprosjektet «Familie og individuelt tilpasset barselomsorg» og komitéens påpekning av at studiens design fokuserer på den tradisjonelle kjernefamilien og ber om en begrunnelse og refleksjon rundt eksklusjons- og inklusjonskriteriene. Vi takker for deres påpekning og ønske om klargjøring, og ønsker i størst mulig grad å ha en 'åpen' tilnærming, men må også ha en avgrensning for å kunne få valide og overførbare funn.

Begrunnelse for eksklusjonskriteriene

1) Foreldre med samme kjønn

Rasjonale for studien er grunnet i omlegging av barselomsorgen i Norge til kortere liggetid på sykehuset etter fødsel, og med tidligere og hyppigere oppfølging av den nye familien i kommunehelsetjenesten. Vi ønsker å belyse hvordan tilbudet i barselomsorgen møter familiens behov, og spesifikt om helsetjenesten klarer å møte fedres forventninger og behov.

Det er imidlertid ufravikelig at det er kvinnen som føder barn, og oppfølginga av foreldre og barnet i denne perioden vil det i de fleste tilfeller være kvinner som utskrives fra sykehuset med barnet. I familier med to fedre, er overtakelsen av foreldreansvaret i svært liten grad fra barselavdelinger ved norske sykehus. Det vil derfor ikke være aktuelt å fokusere på to fedre i denne studien. Men vi ønsker fokus på fars forventninger og erfaringer, hvilke utelukker inklusjon av to mødre i forskningsprosjekt. Hadde vi bare hatt mødre som inklusjonskriterier, hadde vi ikke fått belyst fedres forventninger og erfaringer. Det er behov for mer forskning på foreldre av samme kjønn og deres erfaringer fra svangerskap, fødsel- og barselomsorgen. En av veilederne til denne studien, er med i et forskerteame som er i gang med å planlegge et internasjonalt forskningsprosjekt med fokus på likekjønnede foreldre.

Det er også et annet element som ligger til grunn for at vi ønsker å intervjue mødre og fedre, og det er det faktum at det i dag fortsatt er nesten utelukkende kvinner som jobber som jordmødre og helsesykepleiere i den kommunale barselomsorgen. Og stiller spørsmål om denne kjønns ubalansen har betydning for hvordan nye fedre opplever seg møtt, ivaretatt og inkludert i dette tjenestetilbudet.

2) Foreldre som ikke bor sammen

Målet om familiefokus, omsorg for felles barn i det daglige, foreldres felles opplevelser av å være «en ny familie», opplevelser av behov for støtte og forventninger til og erfaringer med barselomsorgen bidro til at vi valgte å ha det som et eksklusjonskriterium at mor og far ikke bor sammen. Refleksjoner i etterkant av REKs svar har ført til at vi har valgt å fjerne dette kriteriet da vi ser at det kan være foreldre som får barn og har felles omsorg og oppfølging av barnet uten å bo sammen. Vi ønsker å gå åpent ut og ser at dette eksklusjonskriteriet potensielt ville kunne bidra til et snevrere datamateriale.

Informasjonsskrivet revideres i henhold til REK sine merknader.

Forskningsansvarlig institusjons logo (Universitetet i Stavanger) er satt på informasjonsskriv. Informasjon om godkjenning av REK med ref.nr. er påført informasjonsskriv, samt epostadressen til personvernombudet ved Universitetet i Stavanger (se vedlegg).

Vedr. samarbeid med utlandet:

Det planlegges som angitt i vedlagt prosjektplan et utenlandsopphold i Australia eller USA, men det inngår ikke i disse planene utsending av data til utlandet. Det foreligger heller ingen planer om å medbringe data, dele data eller samarbeide med dem i forhold til dette datamaterialet.

Dato: 1. oktober 2019 kl. 14:35:15 CEST
Til: marit.alstveit@uis.no, post@uis.no
Emne: REK vest tar informasjonsskriv og refleksjon til orientering

Vår ref. nr.: 2019/1024

Prosjekttittel: Familie og individuelt tilpasset barselomsorg

Prosjektleder: Marit Alstveit

Til Marit Alstveit.

Vi viser til oppgave besvart den 06.09.2019 med revidert informasjonsskriv, opplysninger om samarbeid med utlandet og en begrunnelse for inklusjons- og eksklusjonskriterier. REK vest tar revidert informasjonsskriv og opplysningene om utenlandssamarbeid til orientering og har ingen ytterligere merknader.

Prosjektleder har begrunnet hvorfor foreldre med samme kjønn ekskluderes, og reflektert rundt eksklusjonen av foreldre som ikke bor sammen. Ettersom prosjektgruppen ønsker å gå åpent ut i innsamlingen av datamaterialet har prosjektgruppen valgt å fjerne som eksklusjonskriterium at mor og far ikke bor sammen. REK vest tar til orientering at sistnevnte eksklusjonskriterium fjernes og har ingen ytterligere merknader.

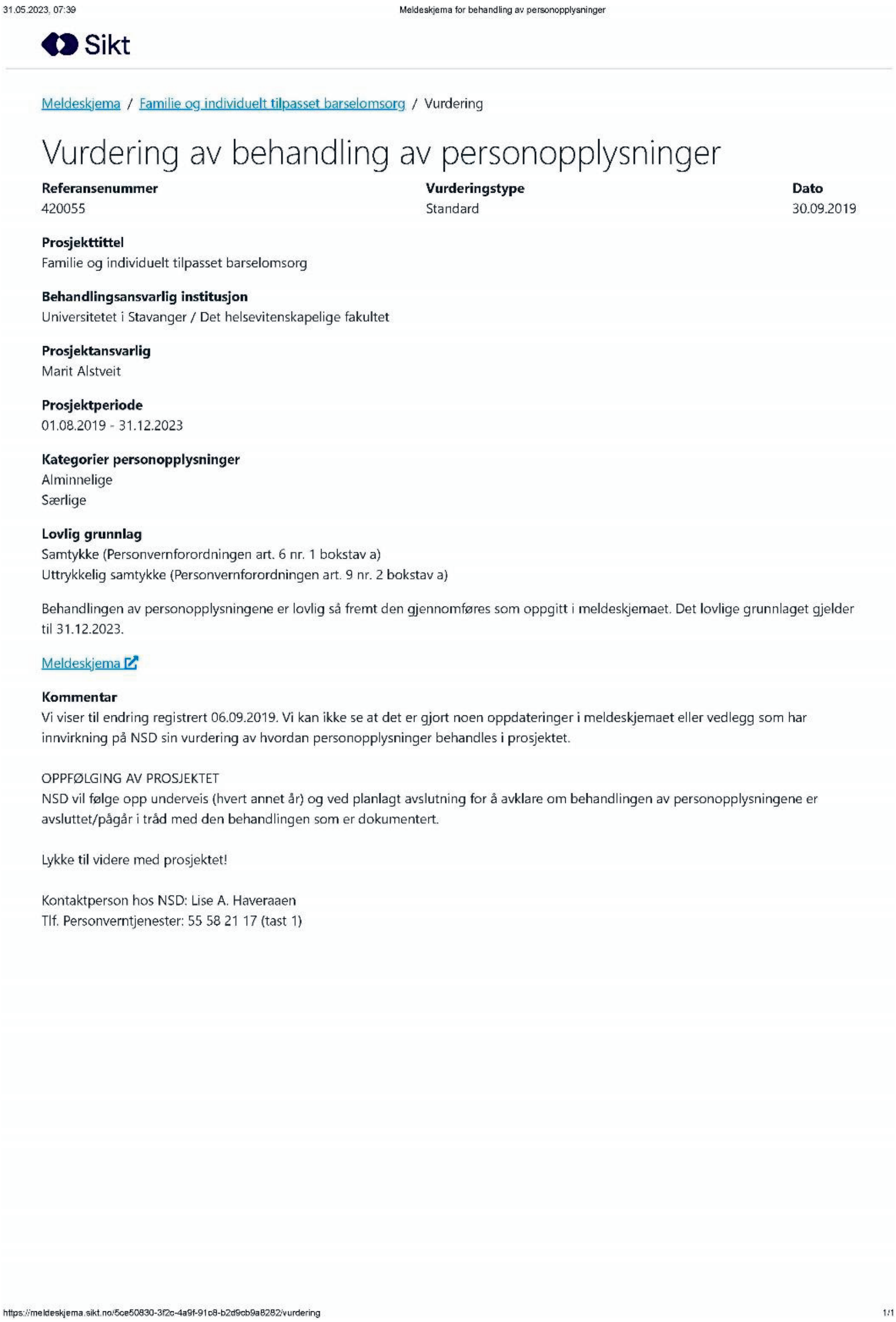
Med vennlig hilsen

Fredrik Rongved

rådgiver

T: 55978498

Appendix II - Approval from the Norwegian Agency for Shared Services in Education and Research (SIKT) and data management plan



31.05.2023, 07:39 Meldeskjema for behandling av personopplysninger

Meldeskjema / Familie og individuelt tilpasset barselomsorg / Vurdering

Vurdering av behandling av personopplysninger

Referansenummer	**Vurderingstype**	**Dato**
420055	Standard	30.09.2019

Prosjekttittel
Familie og individuelt tilpasset barselomsorg

Behandlingsansvarlig institusjon
Universitetet i Stavanger / Det helsevitenskapelige fakultet

Prosjektansvarlig
Marit Alstveit

Prosjektperiode
01.08.2019 - 31.12.2023

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 31.12.2023.

Meldeskjema

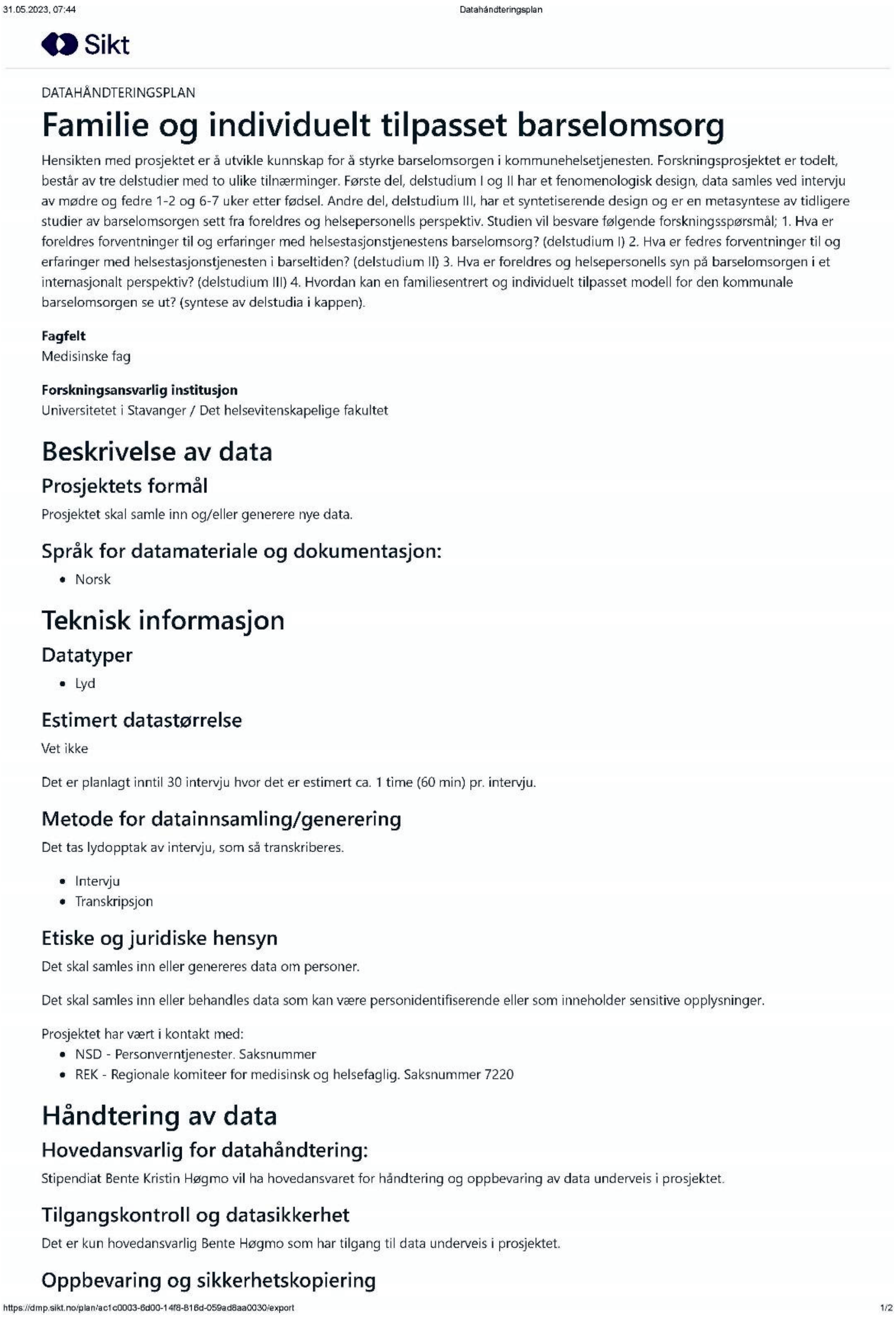
Kommentar
Vi viser til endring registrert 06.09.2019. Vi kan ikke se at det er gjort noen oppdateringer i meldeskjemaet eller vedlegg som har innvirkning på NSD sin vurdering av hvordan personopplysninger behandles i prosjektet.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp underveis (hvert annet år) og ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet/pågår i tråd med den behandlingen som er dokumentert.

Lykke til videre med prosjektet!

Kontaktperson hos NSD: Lise A. Haveraaen
Tlf. Personverntjenester: 55 58 21 17 (tast 1)

https://meldeskjema.sikt.no/5ce50830-3f2c-4a9f-91c8-b2d9cb9a8282/vurdering 1/1



Sikt

DATAHÅNDTERINGSPLAN

Familie og individuelt tilpasset barselomsorg

Hensikten med prosjektet er å utvikle kunnskap for å styrke barselomsorgen i kommunehelsetjenesten. Forskningsprosjektet er todelt, består av tre delstudier med to ulike tilnærminger. Første del, delstudium I og II har et fenomenologisk design, data samles ved intervju av mødre og fedre 1-2 og 6-7 uker etter fødsel. Andre del, delstudium III, har et syntetiserende design og er en metasyntese av tidligere studier av barselomsorgen sett fra foreldres og helsepersonells perspektiv. Studien vil besvare følgende forskningsspørsmål; 1. Hva er foreldres forventninger til og erfaringer med helsestasjonstjenestens barselomsorg? (delstudium I) 2. Hva er fedres forventninger til og erfaringer med helsestasjonstjenesten i barseltiden? (delstudium II) 3. Hva er foreldres og helsepersonells syn på barselomsorgen i et internasjonalt perspektiv? (delstudium III) 4. Hvordan kan en familiesentrert og individuelt tilpasset modell for den kommunale barselomsorgen se ut? (syntese av delstudia i kappen).

Fagfelt
Medisinske fag

Forskningsansvarlig institusjon
Universitetet i Stavanger / Det helsevitenskapelige fakultet

Beskrivelse av data

Prosjektets formål

Prosjektet skal samle inn og/eller generere nye data.

Språk for datamateriale og dokumentasjon:

- Norsk

Teknisk informasjon

Datatyper

- Lyd

Estimert datastørrelse

Vet ikke

Det er planlagt inntil 30 intervju hvor det er estimert ca. 1 time (60 min) pr. intervju.

Metode for datainnsamling/generering

Det tas lydopptak av intervju, som så transkriberes.

- Intervju
- Transkripsjon

Etiske og juridiske hensyn

Det skal samles inn eller genereres data om personer.

Det skal samles inn eller behandles data som kan være personidentifiserende eller som inneholder sensitive opplysninger.

Prosjektet har vært i kontakt med:
- NSD - Personverntjenester. Saksnummer
- REK - Regionale komiteer for medisinsk og helsefaglig. Saksnummer 7220

Håndtering av data

Hovedansvarlig for datahåndtering:

Stipendiat Bente Kristin Høgmo vil ha hovedansvaret for håndtering og oppbevaring av data underveis i prosjektet.

Tilgangskontroll og datasikkerhet

Det er kun hovedansvarlig Bente Høgmo som har tilgang til data underveis i prosjektet.

Oppbevaring og sikkerhetskopiering

31.05.2023, 07:44 Datahåndteringsplan

Innsamlet data og koblingsnøkkel lagres på kryptert minnepinne jmfr. gjeldende retningslinjer ved Universitetet i Stavanger 2019. Kryptert minnnepinne oppbevares i låst skap på Stipendiat Bente Høgmos kontor ved Universitetet i stavanger. Dette er i tråd med samtykke gitt fra deltakerne i studien.

Langtidslagring og deling av data

https://dmp.sikt.no/plan/ac1c0003-6d00-14f8-816d-059ad8aa0030/export 2/2

Appendix III - Information letter and consent form

Universitetet
i Stavanger

Vil du/dere delta i forskningsstudien
«Familie og individuelt tilpasset barselomsorg»?

Forespørsel om å bli intervjuet om forventninger til og erfaringer med helsestasjonens tilbud etter fødsel

Dette er en forespørsel til dere som venter barn snart eller nylig har blitt mor og far, om deltakelse i en forskningsstudie hvor formålet er å få kunnskap om foreldres erfaringer med den kommunale barselomsorgen.

Formål

Barselomsorgen er i endring og liggetiden for mor og barn på sykehus etter fødsel har blitt kortere. Forskningsstudien er et doktorgradsprosjekt og basert på blant annet foreldres erfaringer, har en som mål å utvikle en modell for den kommunale barselomsorgen.

Hvem er ansvarlige for forskningsprosjektet?

Prosjektet vil bli utført av undertegnede, doktorgradsstipendiat Bente Kristin Høgmo, i samarbeid med førsteamanuensis Marit Alstveit og professor Terese Bondas. Alle ansatt ved Det helsevitenskapelige fakultet, Universitetet i Stavanger.

Hvorfor får dere spørsmål om å delta?

Målgruppen vi søker etter forventningene og erfaringene til er kvinner og menn som nylig har fått barn, behersker skandinavisk språk, hvor kvinnen har hatt en fødsel uten komplikasjoner, samt at mor og barn reiser hjem fra sykehuset innen tredje døgn etter fødselen uten spesielle oppfølgingsbehov.

Ledere for helsestasjonstjenesten og svangerskapsomsorgen i kommuner, samt ledere for føde/barselavdelingene ved sykehus har fått informasjon om forskningsstudien og vil bidra til å informere aktuelle mødre og fedre om studien.

Hva innebærer det for dere å delta?

I studien vil vi anvende intervju som metode og om dere er villig til å delta, vil jeg be dere om å få intervjue dere to ganger. Første gang sammen (med mulighet for hver for dere om ønskelig) og andre gang hver for dere. Det første intervjuet gjennomføres i løpet av 1.-2. uke etter hjemkomst fra sykehuset og har fokus på forventninger til helsestasjonens tilbud, mens det andre vil være rundt 6.-7. uke etter fødselen og fokuset vil være erfaringer med helsestasjonens tilbud og oppfølging i barseltiden. Intervjuene vil vare ca. en time. Stedet for gjennomføring av intervjuet avtales med hver enkelt og kan evt. være hjemme hos dere, på undertegnedes kontor eller ved helsestasjonen dere bruker. Det er ønskelig at intervjuene utføres uforstyrret og i rolige omgivelser. For å sikre korrekt gjengivelse av samtalen vil den bli tatt opp som lydfil. Intervjuene skrives deretter ned og bearbeides til anvendelse av studien.

Det er frivillig å delta

Deltakelse i studien er frivillig. Om du/dere gir samtykke til å delta, kan du/dere når som helst og uten å oppgi noen årsak, trekke samtykket tilbake. Dette vil ikke ha noen negative konsekvenser for deg/dere hvis dere ikke vil delta eller senere velger å trekke deg/dere.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil bare bruke opplysningene om dere til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernreglementet.

Personidentifiserbare opplysninger vil bli oppbevart atskilt fra det øvrige datamaterialet og alt som vedrører intervjuene vil oppbevares innelåst ved forskningsinstitusjonen (Universitetet i Stavanger).

Hva skjer med opplysningene dine når vi avslutter forskningsstudien?

Når forskningsstudien er ferdig vil lydfilene slettes og alt datamaterialet anonymiseres. Det er kun undertegnede og veilederne knyttet til studien som har tilgang til de innhentede dataene. Når resultatene fra studien publiseres vil det ikke være mulig å identifisere dere i materialet. Forventet studieslutt er ved utgangen av 2023.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- å få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandling av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke. Forskningsstudien er fremlagt for NSD og REK (ref.nr. 7220).

Har du spørsmål om intervjuet eller studien, er du velkommen til å ta kontakt med undertegnede.

Om du er villig til å la deg intervjue, kan du kontakte undertegnede på telefon/SMS eller e-post, eller gi beskjed til din jordmor eller helsesykepleier om du ønsker at jeg skal ta kontakt med dere slik at vi kan gjøre en avtale om tid og sted for intervju.

Med vennlig hilsen

Bente Kristin Høgmo Doktorgradsstipendiat, helsesykepleier Tlf. 90924449 bente.k.hogmo@uis.no	Marit Alstveit Førsteamanuensis, PhD, helsesykepleier Tlf. 51834181 marit.alstveit@uis.no	Terese Bondas Professor, PhD, helsesykepleier Tlf. 51834519 terese.e.bondas@uis.no

Det helsevitenskapelige fakultet, Universitetet i Stavanger

Personvernombud ved Universitetet i Stavanger; personvernombud@uis.no

---

Samtykke til deltakelse i forskningsstudie

Jeg har mottatt og forstått informasjon om forskningsstudien «Familie og individuelt tilpasset barselomsorg», og er villig til å delta i studien ved å la meg intervjue. Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet ved utgangen av 2023.

(Sign., prosjektdeltaker - mor, dato)

(Sign., prosjektdeltaker - far, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Sign., rolle i studien, dato)

Appendix IV - Interview guide, joint and individual interviews

Universitetet
i Stavanger

Intervjuguide

Fenomen: Nye foreldres forventninger til og erfaringer med den kommunale barselomsorgen i barseltiden (de første seks ukene etter fødsel).

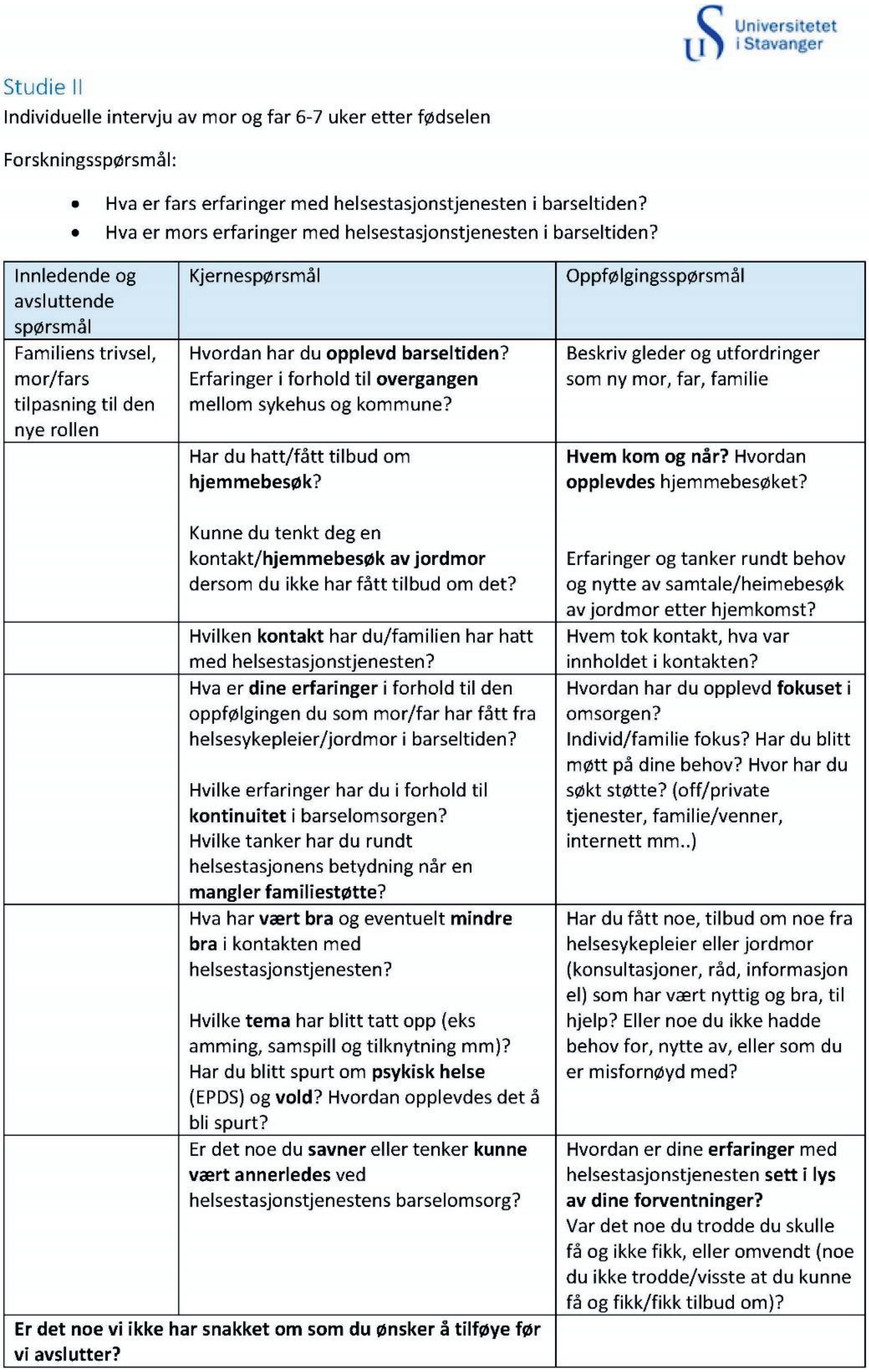
Studie I

Parintervju (mor og far sammen) 1-2 uker etter fødselen

Forskningsspørsmål:

Hva er foreldrenes forventninger til helsestasjonstjenestens barselomsorg?

Innledende og avsluttende spørsmål	Kjernespørsmål	Oppfølgingsspørsmål
Alder, hvor lenge har dere vært sammen, utdanning/yrke, antall felles barn/alder, hjemreise fra sykehus	Kan dere **beskrive** hvordan den første tiden vært for dere og babyen (og evt søsken) etter at dere kom hjem fra sykehuset?	Hva er **viktig** for deg som mamma/pappa akkurat nå og hvilke **behov** har dere? Hva er viktig for dere som familie?
	Hvilke **forventninger** har dere til oppfølgingen fra helsestasjonstjenesten i barseltiden?	Hva ønsker dere å få av støtte, oppfølging og omsorg - **individuelt** og som **familie**?
	Hva kjenner dere til om den kommunale barselomsorgen og det som helsestasjonstjenesten kan tilby, og hvordan fikk dere denne kunnskapen? Dersom dere **ikke har fått informasjon** om helsestasjonstjenesten – hvordan og når skulle dere ønske dere hadde fått den?	Hvordan tror dere at dere som mor, far, familie – vil **bruke tjenesten** i barseltiden? (Eks. informasjon av jordmor i slutten av svangerskapet, muntlig/skriftlig, på nettet, mail, el. møtt helsesykepleieren deres før fødsel)
	Dersom dere har vært i kontakt med helsestasjonen etter hjemkomst fra sykehuset, hva er deres **erfaringer med tilbudet** så langt? Hva er viktig for dere for å være **trygg i relasjonen** med helsesykepleier?	**Hva trengte dere** (mor, far, baby eller søsken) og hvordan opplevde dere å bli møtt og ivaretatt? **Hvordan var fokuset** (mor, baby, far, søsken, familie)? **Fikk dere** det den hjelpen /støtten som dere hadde behov for?
Er det noe dere har tenkt på under intervjuet som dere ønsker å tilføye? **Hvordan opplevde dere det å bli intervjuet?**		



Universitetet i Stavanger

Studie II

Individuelle intervju av mor og far 6-7 uker etter fødselen

Forskningsspørsmål:

- Hva er fars erfaringer med helsestasjonstjenesten i barseltiden?
- Hva er mors erfaringer med helsestasjonstjenesten i barseltiden?

Innledende og avsluttende spørsmål	Kjernespørsmål	Oppfølgingsspørsmål
Familiens trivsel, mor/fars tilpasning til den nye rollen	Hvordan har du **opplevd barseltiden**? Erfaringer i forhold til **overgangen** mellom sykehus og kommune?	Beskriv gleder og utfordringer som ny mor, far, familie
	Har du hatt/fått tilbud om **hjemmebesøk**? Kunne du tenkt deg en kontakt/**hjemmebesøk av jordmor** dersom du ikke har fått tilbud om det?	**Hvem kom og når?** Hvordan **opplevdes** hjemmebesøket? Erfaringer og tanker rundt behov og nytte av samtale/heimebesøk av jordmor etter hjemkomst?
	Hvilken **kontakt** har du/familien har hatt med helsestasjonstjenesten?	Hvem tok kontakt, hva var innholdet i kontakten?
	Hva er **dine erfaringer** i forhold til den oppfølgingen du som mor/far har fått fra helsesykepleier/jordmor i barseltiden? Hvilke erfaringer har du i forhold til **kontinuitet** i barselomsorgen? Hvilke tanker har du rundt helsestasjonens betydning når en **mangler familiestøtte**?	Hvordan har du opplevd **fokuset** i omsorgen? Individ/familie fokus? Har du blitt møtt på dine behov? Hvor har du søkt støtte? (off/private tjenester, familie/venner, internett mm..)
	Hva har **vært bra** og eventuelt **mindre bra** i kontakten med helsestasjonstjenesten? Hvilke **tema** har blitt tatt opp (eks amming, samspill og tilknytning mm)? Har du blitt spurt om **psykisk helse** (EPDS) og **vold**? Hvordan opplevdes det å bli spurt?	Har du fått noe, tilbud om noe fra helsesykepleier eller jordmor (konsultasjoner, råd, informasjon el) som har vært nyttig og bra, til hjelp? Eller noe du ikke hadde behov for, nytte av, eller som du er misfornøyd med?
	Er det noe du **savner** eller tenker **kunne vært annerledes** ved helsestasjonstjenestens barselomsorg?	Hvordan er dine **erfaringer** med helsestasjonstjenesten **sett i lys av dine forventninger?** Var det noe du trodde du skulle få og ikke fikk, eller omvendt (noe du ikke trodde/visste at du kunne få og fikk/fikk tilbud om)?
Er det noe vi ikke har snakket om som du ønsker å tilføye før vi avslutter?		

Appendix V - Overview of studies included in previous research

Table . Overview of included studies in previous reserch (chapter 2.2)

First author	Country	Design	Objective/title	Sample	Perspectives	Relevant results
Alstveit et al., 2010	Norway	Qualitative study	Experiences of social relationships while on maternity leave	N=9	First time mothers	Being confirmed by other mothers, balancing between being a mother and an employee
Askelsdottir et al., 2013	Sweden	Retrospective, Case-control study	Experiences of home care after early discharge	N=96	Mothers	Greater sense of security in the first postnatal week
Aune et al., 2017	Norway	Quantitative study	Influences of early postnatal home visit by midwife	N=183	Mothers	Significant influence on caring for the newborn, mental health, feeling of being recognised and supported
Baldwin et al., 2018	-	Systematic review	Mental health and well-being during the transition to fatherhood	N=22	Fathers	New fatherhood identity, negative feelings and fear, stress and coping, lack of support, what fathers want, positive aspects of fatherhood.
Barimani et al., 2017	Sweden	Qualitative, secondary analysis	Facilitating and inhibiting factors in transition to parenthood – health professionals support of parents	N=60	Mothers and fathers	Facilitating: parenthood a normal part of life, social/professional support, information, gender equality. Inhibiting: stress, lack of control, unprepared, lack of information and professional support, lack of healthcare resources.
Barimani & Vikström, 2015	Sweden	Focus group discussion	Parents experience of support from health professionals in the early postpartum period	N=44	Mothers and fathers	Access to care system, consistent advice, sufficient information, information that empowers parents.
Black, 2023	-	Meta-synthesis	Fathers' well-being in the first postnatal year: How health visitors can help	N=15	Fathers	Role negotiation, self-efficacy, separation/rejection affect well-being. Feeling ignored/sidelined by health professionals. Wish for more knowledge, nurse/father groups.
Bäckström et al., 2018	Sweden	Prospective longitudinal cohort study	Evaluate factors associated with quality of couple relationship, during pregnancy and the first six months of parenthood	N=207	First-time mothers and partners	The childbirth and transition to parenthood have positive impact on parents' abilities to cope with life even though their quality of couple relationship decrease during transition to parenthood.
Chin et al., 2011	-	Meta-synthesis	Fathers' experiences of transition to fatherhood	N=6	Fathers	Detached, surprise and confusion, role as father, redefining self and relationship with partner.
Danbjørg et al., 2014	Denmark	Qualitative, feasibility study	Do families after early postnatal discharge need new ways to communicate with the hospital?	N=37	Parents and healthcare professionals	Importance of individualised postnatal follow-up, increased access to healthcare professionals, timely and tailored information to specific needs.
Dahlberg et al., 2016	Norway	Qualitative	Experiences of home visits by midwives in the early postnatal period	N=24	Mothers	The importance of relational continuity, postpartum talk and vulnerability in the early postnatal period.
Delicate et al., 2018	-	Systematic review and meta-synthesis	Impact of becoming parents on the couple relationship	N=12	Parents	Change in relationship, focus on the baby, shifts in communication patterns, changes in sexual relations, strain on relationship, strengthened relationships.

Table . Overview of included studies in previous reserch (chapter 2.2)

Eddy et al., 2019	USA	Qualitative	Postpartum depression in men	N=27	Fathers	Needing education, adhering to gender expectations, repressing feelings, being overwhelmed, experience of neglect.
Edhborg et al., 2016	Sweden	Qualitative	Experiences in the first postpartum year by fathers with depressive symptoms	N=19	Fathers	Feeling of powerlessness and loss of control, stress and worries for infant, conflicts between family and work, lack of support in everyday life, impaired partner-relationship.
Engström et al., 2019	Sweden	Qualitative	Mothers in same-sex relationships and equality in parenthood	N=20	Mothers and co-mothers	Request professional support to achieve equal parenthood.
Engström et al., 2022	Sweden	Focus group discussion	Professionals' experiences of supporting two-mother families	N=13	Midwives and nurses	Striving to be open-minded, aiming at providing equal support, struggling with communication, lack of information and competence.
Ellberg et al., 2008	Sweden	Cross-sectional, questionnaires	New parents' discontent with postnatal care	N=1474	Mothers and fathers	The close emotional attachment between the parents not always supported by staff, father treated as outsider, care described as a "woman's world".
Finlayson et al., 2020	-	Meta-synthesis	What matters to women in the postnatal period	N=36	Mothers	Important to develop a sense of confidence, competence as mother, adjust changes in intimate and family relationships.
Finlayson et al., 2023	-	Qualitative evidence synthesis	Factors influencing uptake of postnatal care from the perspective of fathers, partners, and other family members	N=30	Fathers, partners, and other family members	Informational, care and psychosocial support needs (especially fathers) are not fulfilled by healthcare providers. Access and availability important.
Forster et al., 2008	Australia	Focus groups	Women's expectations and experiences of early postnatal care	N=%"	Mothers	Anxiety and fear, transition to parenthood and parenting, lack of confidence, professional support important especially for first-time mothers.
Garvan, 2016	Australia	Qualitative	Transition to motherhood	N=16	First-time mothers	One half of the mothers had difficulties in their relationship with partner, for some it was traumatic, most did not speak with their health nurse about these concerns.
Giltenane et al., 2022	Ireland	Qualitative	Work environment challenging care quality in first postnatal visit	N=19	PHNs	Challenges of providing a quality service, workload demands, language barriers, lack of support from managers.
Giltenane et al., 2021	Ireland	Qualitative	The role of PHN in the first postnatal visits	N=14	PHNs and mothers	PHNs crucial for providing support during first postnatal visit, lack of standardisation of care, nurses identified relationship building, empowerment and health promotion as pivotal.
Haga et al., 2012	Norway	Qualitative	Depressive symptoms and well-being among first-time mothers	N=12	First-time mothers	Social support and managing breastfeeding important with regard to well-being and depressive symptoms.

Table . Overview of included studies in previous reserch (chapter 2.2)

Hammarlund et al., 2015	Sweden	Qualitative	Child health center nurses' recognition of postnatal depression in fathers	N=10	Nurses	Paternal PND vague/difficult to detect, limited experiences, hard to grasp fathers' health status, lack of routines, daily work influenced by gender attitudes.
Hjälmhult & Lomberg, 2012	Norway	Focus group discussions	Present a theoretical account of mothers first period at home with their newborn	N=26	Mothers	Concerned about preserving control and integrity, developing competence as mother, changing focus in relationships.
Hodgson et al., 2020	United Kingdom	Qualitative	The experiences of first-time fathers in perinatal services	N=12	First-time fathers	Feeling excluded from conversations, wish for someone to talk to with similar experiences, feeling of abandoning their partner and baby when returning to work, opening hours at CHC does not fit working fathers.
Hrybanova et al., 2019	Sweden	Qualitative	First-time fathers' experiences of professional support from child health nurses	N=12	First-time fathers	Would like information, commitment and availability from the nurse. Experience inequality in support, a wish for parental groups.
Johansson et al., 2010	Sweden	Qualitative	First-time parents' experiences of home-based postnatal care	N=21	Mothers and fathers	Self-reliance, strength, freedom and independence, professional support in the home.
Johansson et al., 2019	Sweden	Mixed method	Mothers' experiences in relation to a home-based model of midwifery care	N=180	Mothers	Discharge 6 to 12 hours after birth, positive postnatal experience, phone calls, home visit(s) and hospital visit(s).
Johansson & Thies-Lagergren, 2022	Sweden	Qualitative	Experience of the decision-making process for home-based postnatal care when discharged early	N=24	Mothers	The autonomy to decide on the postnatal care model.
Kowlessar et al., 2014	United Kingdom	Qualitative	First-time fathers' experiences of parenting during the first year	N=10	First-time fathers	Helplessness, trial and error parenting, "She leads, I follow", working together, gaining confidence, regaining control.
Kronborg et al., 2012	Denmark	Cross-sectional study	Effect of early postpartum home visits by health visitors during a period of strike	N=5209	Mothers and health visitors	Shorter duration of breastfeeding for unvisited mothers, significant higher use of medical services.
Kokab et al., 2022	United Kingdom	Qualitative	Community midwives views of postnatal care in the UK	N=47	Midwives	Time of discharge, problematic discharges, strategies to address increases in earlier discharge.
Kurth et al., 2016	Switzerland	Focus group discussions	What parents of newborns need after early discharge from hospital	N=24	Parents	Mothers feeling physically strained, significant needs for practical and medical support, challenges in accessing postnatal care services, lacking inter-professional coordination.
Leahy-Warren et al., 2022	-	Scoping review	Fathers' perceptions and experiences of support during the perinatal period	N=23	Fathers	Wish to be an involved father to their child, be a role model, becoming a father a significant status in society which contributes to self-efficacy as fathers.

Table . Overview of included studies in previous reserch (chapter 2.2)

Lindberg et al., 2008	Sweden	Quantitative	Expectations of post-partum care	N=120	Pregnant women	Want to decide for themselves when to be discharged from the hospital, the father of the child expected to be the most important person postnatally.
Nilsson et al., 2015	-	Meta-synthesis	Parental experiences of early postnatal discharge	N=10	Parents	Feeling/taking responsibility, a time of insecurity, being together as a family, striving to be confident.
Noonan et al., 2017	-	Meta-synthesis	Public health nurses role in the identification and management of perinatal mental health problems	N=14	PHNs	Screening tools or intuition, challenges in detection. Barriers included availability of referral pathways and time.
Persson et al., 2010	Sweden	Focus group discussions	Factors influencing mothers' sense of security in the first postnatal week	N=14	Mothers	Being met as an individual, given relevant information, knowing who to ask, having partner/significant others close to hand.
Rautio, 2013	Finland	Qualitative	Parents' experiences of early support	N=9	Mothers and fathers	Experiencing home visits as useful, purpose of home visiting not always clear, varied experiences with child health clinics.
Rydström et al., 2021	Sweden	Qualitative	Mothers' lived experiences of initial breastfeeding complications	N=12	Mothers	Feelings of powerlessness, failure, despair, and sorrow.
Sacks et al., 2022	-	Qualitative evidence synthesis	Factors that influence uptake of routine postnatal care, views and experiences of women	59 articles	Women	Factors that influence women's utilization of postnatal care are interlinked, and include access, quality, and social norms. Increased need for emotional and psychosocial support in this time, in addition to clinical care.
Shorey et al., 2017	Singapore	Qualitative	First-time fathers' postnatal experiences and support needs	N=15	First-time fathers	Unprepared and challenged, sleep-deprived, confused and lack of confidence, a need to bond with the baby, feeling left out by nurses who focuses on mother and baby.
Shorey & Ang, 2019	-	Meta-synthesis	Experiences, needs, and perceptions of paternal involvement during the first year after their infants' birth	N=13	Fathers	Fathering responsibility and parenting satisfaction developed over time and influenced behaviour. Changing from self-oriented to family-oriented. Needs were identified.
Shaw et al., 2006	-	Systematic review	Effectiveness of Postpartum Support to Improve Maternal Parenting, Mental Health, Quality of Life, and Physical Health	22 studies	Women	No RCT evidence was found to endorse universal provision of postpartum support to improve parenting, maternal mental health, maternal quality of life, or maternal physical health. There may be some infant benefits, including improved breastfeeding duration.
Slomian et al., 2017	Belgium	Qualitative study	Identify maternal needs following childbirth	N=37	Mothers, fathers, and professionals	Need of information, need of psychological support, need to share experience and need of practical and material support.
Solberg et al., 2022	Norway	Qualitative	A qualitative study of men's emotional experiences in the transition to fatherhood	N=13	Fathers	From self-focus to family perspective, emotional vulnerability, from insecurity to self-reassurance.

Table . Overview of included studies in previous reserch (chapter 2.2)

Steen et al., 2012	-	Meta-synthesis	Fathers encounters with pregnancy, birth and maternity care	N=23	Fathers	Fathers feel as a partner and parent, experience of maternity care services as "not-patient and not-visitor", many feel excluded.
Thomas et al., 2011	Sweden	Prospective longitudinal study	Fathering in the first few months	N=827	Fathers	Support from midwife or others close to the father did not impact fathers' thoughts about difficulties of being a parent during pregnancy, lack of support from the partners after birth increased concern.
Tveit & Söderhamn, 2015	Norway	Qualitative	How first-time mothers cope with childcare in the early postnatal period	N=7	Mothers	Being prepared, to seek support and to get to know the baby. Breastfeeding important to manage.
Valla et al., 2022	Norway	Quantitative	Factors associated with maternal overall quality of life six months postpartum	N=86724	Mothers and children	Joy of having a baby, high relationship satisfaction and having a baby with normal sleep are associated with overall QoL.
Walker et al., 2019	-	Qualitative systematic review	Women's successful transition to motherhood during the early postnatal period	N=19	Mothers	Connection between women and midwives, postnatal needs met, education and support, cultural/family influence.
Wells, 2016	Sweden	Meta-ethnographic analysis	Fathers are still not receiving the support they want and need from Swedish child health professionals	N=62	Fathers	Want to have a trusting relationship with PHNs, CHCs designed for mothers, did not feel involved to the same extent as mothers, wanted to feel welcome and receive answers to their questions, unequal treatment.
Wells & Lang, 2016	-	Meta-synthesis/systematic literature review	The support of same-sex mothers in the Nordic child health field	N=10	Mothers and co-mothers	Acceptance to same-sex mothers, disclosing sexual orientation, heteronormativity, being the other parent.
Werner-Bierwisch et al., 2018	-	Integrative review	Mothers' and fathers' sense of security in the context of pregnancy, childbirth and the postnatal period	N=11	Mother and fathers	Security in relation to confidence and control, lack of security and coping strategies.
Wiklund et al., 2018	-	Systematic review	New parents experience of information and sense of security related to postnatal care	N=10	Mothers and fathers	Parents prefer "non-judgemental" attitude from staff, want to be met as an individual. Support from staff and family described as significant, emotions were characterised by anxiety and/or fear.
Yonemoto et al., 2021	-	Review	Schedules for home visits in the early postpartum period	N=16	Women	Individualised care probably improves depression scores, increasing home visits might improve exclusive breastfeeding rates, increased maternal satisfaction.
Zadoroznyj et al., 2015	Australia	Survey	Mothers post-birth care experiences	N=1100	Mothers	Experiences of inadequate and/or inconsistent breastfeeding support.